ALAMEDA BEHAVIORAL HEALTH CARE SERVICES (ACBHCS)
SPECIALTY MENTAL HEALTH SERVICES (SMHS) FAQ'S

New/Revised (from v.6.22.17) FAQ's in Red.

For More Comprehensive Guidelines see the MH Provider Manuals:
http://www.acbhcs.org/providers/QA/audit.htm

Index:

I. Assessment

Cultural & Linguistic Considerations

Q1. What Sexual Orientation and Gender Identity/Expression (SO/GIE) data must be collected at Initial and Annual Assessment.

A1. The fields are as follows:

Preferred Last Name:		**Preferred First Name:**		**D.O.B.:**		
What is your Pronoun:	☐ She/Her	☐ He/Him	☐ They/Them	☐ Unknown/ Not Reported		
	☐ Other					
Sex Assigned at Birth:	○ Unknown	○ Male	○ Female	○ Intersex	○ Other	
Gender Identity:	☐ Unknown	☐ Male	☐ Female	☐ Intersex	☐ Gender Queer	☐ Decline to State
	☐ Other					
	Transgender:	☐ Male to Female	☐ Female to Male			
SEXUAL ORIENTATION:	☐ Unknown	☐ Bisexual	☐ Declined to State	☐ Gay	☐ Gender Queer	
	☐ Heterosexual/Straight	☐ Lesbian	☐ Questioning	☐ Queer		
	☐ Other:					

For Pronoun, Gender Identity & Sexual Orientation—select all that apply.

Q2. Are there other SO/GIE considerations when developing the Assessment template or when inquiring with the client and/or family?
A2a. Yes, rather than asking about Mother or Father, ask about Parents, Caretakers (inclusive of extended family) or Guardians.
A2b. Also, Rather than asking is someone is married or has a husband or wife, ask if they have a Significant Other or Domestic Partner.

Diagnoses
Q1. What are the charting diagnoses requirements?
A1. 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. It must include the same diagnoses entered into InSyst, plus any additional diagnoses the client may have. Diagnoses in the clinical record must be supported by documentation including: specific signs, symptoms, and timeframes of the diagnoses that client exhibits—unless it is a diagnosis gathered "by history" and is not a focus of treatment. All Diagnoses must include the ICD-10 code and the appropriate DSM descriptor (diagnosis name) with specifiers and severity (when appropriate). See SMHS FAQ, Section V. Claiming SMHS, and Q24 for InSyst diagnoses requirements.

Safety
Q1. If a client is found to have suicidal/homicidal/other significant risk *ideation* is a Safety Plan required?
A1. Yes, if at any point ideation is identified (having occurred anytime in the past 90 days)--both a comprehensive Risk Assessment AND a formal written Safety Plan must be developed in coordination with the client. Also, see Q2 below.

Q2. What if a client has a history of suicidal/homicidal/other significant risk ideation but is currently stable and has these symptoms controlled.
A2. ACBHCS requires that if a client has had any a suicidal/homicidal/other significant risk ideation *in the past 90 days* that both a comprehensive Risk Assessment AND a formal written Safety Plan must be developed in coordination with the client. *If it has been more than 90 days* since the client last experienced symptoms of suicidal/homicidal/other significant risk ideation the clinical situation must be considered carefully to determine if a comprehensive Risk Assessment AND a formal Safety Plan should be completed. Beyond 90 days of ideation, if it is determined that a Comprehensive Risk Assessment and formal written Safety Plan are not indicated, document the clinical reasoning for this decision.

Q3. What elements must be documented in a comprehensive Risk Assessment and formal Safety Plan?

A3. The Comprehensive Risk Assessment must be documented in the Clinical Record. The Safety Plan must also be documented in writing and provided to the client as a resource for reference as needed. It is crucial that the development of the Plan is a clinical process and that each step is embraced and endorsed by the client. Critical elements of each include:

Comprehensive Risk Assessment (must be documented in Clinical Record):

- *Reason for Comprehensive Assessment*
- *Current Episode:* Current Intent (Subjective Reports & Objective Signs); Plans; Access to Means; and Ideation (Frequency, Intensity & Duration)
- *History of Risks and Attempts* (Self-Harm, Risk to Others, & 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 Crisis Safety Plan*
- *Comprehensive Risk Assessment Resource:*

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

Formal Crisis Safety Plan (written from client's perspective as their plan).

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

- *The Implementation of Safety Plan* (Likelihood of Use and Problem Solve if Obstacles; Regular Review)
- *Resource:* ***www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.doc***

II. ACBHCS System of Care Auditing:

Q1. When a chart is chosen by Alameda County to be audited, will the county recoup money for progress notes/claims that fail to meet Medi-cal ACBHCS documentation standards?
A1. All providers and regulators have a legal and ethical duty to reduce fraud, waste, and abuse. All claims during the 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 minimum documentation requirements to support the service/claim, Alameda County will recoup those funds and return them to the funding source.

Q2. What is a quality comment? Will a claim be recouped if there is a quality comment about it?
A2. Often charts will include enough information to support the claim but will have quality issues. In these instances, feedback describing the quality issues will be provided and require a *Quality Improvement Plan* on the part of the agency to assure improved documentation in the future. These claims are not recouped, but such future claims with poor quality may be recouped--especially if a program fails to improve the quality of their documentation in the future.

Q3. Why are claims outside of the audit period recouped?
A3. In the course of reviewing a chart, if it is determined that claims outside of the audit period are also not supported by documentation in the chart, there is a legal and ethical duty to recoup those funds and return them to the funding source.

Q4. What type of documentation problems would cause claims outside of the audit period to be identified as needing recoupment?
A4. The most common reasons for claims outside the audit period being recouped include:

1: Assessments reviewed were: not completed, not signed, late, etc. (see DHCS Reasons for Disallowances with ACBHCS Comments).
2: Treatment plans reviewed were: not completed, not signed, late, or service modality claimed was not listed, etc.

3: The Severity Screening Tool did not support that the client has moderate to severe impairment to functioning and therefore was not eligible for specialty mental health Medi-Cal services.

ACBHCS makes available on the county's web pages the full set of criteria and regulations that are used during the audit process. Please refer to those exhibits for a full list of items that when found deficient will cause claims to be disallowed. **http://www.acbhcs.org/providers/QA/audit.htm**

Audit Tools for Mental Health Services

- ***Audit Tools***
  1. ***Regulatory Compliance Tool***
  2. ***Plan of Correction and Quality Improvement Plan Template***
  3. ***DHCS & ACBHCS Reasons for Recoupment - updated 7/1/16***
  4. ***Standard Abbreviations***
- ***Diagnoses Lists and Crosswalks:***
  1. ***ACBHCS Mental Inpatient Medi-Cal Included Dx List Alpha by DSM-5 Name***
  2. ***ACBHCS DSM-IV to DSM-5 Mental Health Included Dx Crosswalk by DSM-5 Chapters***
  3. ***ACBHS Mental Inpatient Medi-Cal Included Dx List Numeric by ICD-10 Codes***
  4. ***ACBHCS Mental Health Outpatient Medi-Cal Included Dx List Alpha by DSM-5 Name***
  5. ***ACBHCS General Medical Codes***
  6. ***ACBHCS Psychosocial Dx List Alpha by DSM-5 Name***
  7. ***ACBHCS Psychosocial Dx List Numeric By ICD-10 Code***
- ***MH Authorization and Audit Tools:***
  1. ***ACBHCS M/C Claiming Lock-Out Grid***
  2. ***DHCS & ACBHCS Reasons for Recoupment***
  3. ***ACBHCS MH CQRT Form Adult Child***
  4. ***Regulatory Compliance Tool***
  5. ***Plan of Correction and Quality Improvement Plan Template***
  6. ***ACBHCS SMHS FAQ's***
- ***Mental Health Provider Manuals:***
  1. ***Quality Assurance Manual***
  2. ***ACBHCS MH Clinical Documentation Standards Manual for Master Contract Providers***
  3. ***ACBHCS MH Clinical Documentation Standards for SMH Fee – For-Service Providers (MHP Network Providers)***
  4. ***ACBHCS MH CQRT Manual***

- ***Medi-Cal Compliant Clinical Forms and Templates***
  - ***Sample Medi-Cal Compliant Initial or Annual MH Assessment—Long Form***
  - ***Sample Medi-Cal Compliant Initial MH Assessment—Short Form***
  - ***Sample Medi-Cal Compliant Psychiatric Mental Health Assessment: PDF Word***
  - ***Sample Medi-Cal Compliant Psychiatric Mental Health Client Plan: PDF Word***
  - ***Sample Medi-Cal Compliant Outpatient MH Progress Note: PDF Word***
  - ***Sample Medi-Cal Compliant MH Treatment Plan: PDF Word***

III. Beneficiary Rights

Q1. 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 interest of the patient, clinically?

A1. This particular 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 of his or her medical records, and request that they be amended or corrected, as specified in CFR Secs. 164.524 and 164.526."

Since MHPs are subject to the HIPAA privacy rules, they must grant beneficiaries this right, unless one of the exceptions applies. This is not a brand new requirement; MHPs were already subject to this when the HIPAA privacy rule became effective in April 2003.

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."

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.

IV. CANS/ANSA Documentation Standards

Q1: When do I need to complete the CANS or ANSA?
A1: The CANS or ANSA must be completed at the following timeframes:

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/information shall be used to inform the Initial Client Plan.
At the 6-month mark. A Re-Assessment CANS/ANSA must be completed within the calendar month prior to the 6th month of the EOD.
At Annual Re-Authorization. A Re-Assessment CANS/ANSA must be completed during the annual re-authorization timeframe which is within the calendar month prior to the episode opening month. CANS/ANSA data/information 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 could signal the need to update the Client Plan.
Client Plan Update (New Plan is created). Conversely, since the CANS/ANSA is used to inform the 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 then utilize that additional information to inform the new Client Plan.
At Discharge. A CANS/ANSA must be completed prior to closing the case.

Q2: If we complete the CANS or ANSA in the Objective Arts database (rather than on paper form) do I need to print it out?
A2: Yes. Since the CANS/ANSA document is part of the official medical record, the print out should be included in the consumer's chart (medical record). Staff must sign (electronic signature is okay) with credentials, required co-signatures, and date. Completing it by paper for the medical record, or within an Electronic Health Record is also acceptable. However, once the CANS/ANSA is completed on paper—someone will need to do data entry of the results into the Objective Arts database which is not a claimable service.

Q3: I'm credentialed as a MHRS or Adjunct Staff; can I complete the CANS or ANSA?
A3: No. Due to the clinical nature of the CANS/ANSA, staff who completes a CANS/ANSA must meet the credentialing standards as in the category of Evaluation (CANS/ANSA) on the BHCS Guidelines for Scope of Practice Credentialing grid. That is, Licensed, or Unlicensed (Waivered or Registered) LPHA's; OR Graduate MH Student/Trainees).
http://www.acbhcs.org/providers/QA/docs/training/ACBHCS_Guidelines_Scope_Practice_Credentialing_Provide_Specialty_MH_Services.pdf

Q4: How much time may be claimed for scoring and write-up of the CANS/ANSA?
A4: The initial CANS/ANSA timeframe is expected to be between 30 – 45 minutes. Updates to the initial CANS/ANS are expected to take between 15 – 20 minutes. (One may use the option to copy the original and then modify for the revised in the CANS/ANSA in the Objective Arts Database.)

CANS Resources:
http://www.acbhcs.org/providers/CANS/cans.htm

V. Claiming SMHS

Q1. What are the Specialty Mental Health Services that are eligible for Medi-Cal reimbursement?
A1. Specialty Mental Health Services include:
Rehabilitative Mental Health Services, which include:

- mental health services,
- medication support services,
- day treatment intensive,
- day rehabilitation,
- crisis intervention,
- crisis stabilization,
- adult residential treatment services,
- crisis residential services,
- psychiatric health facility services
- case management—brokerage
- psychiatric inpatient hospital services
- psychiatrist services
- psychologist services
- EPSDT Supplemental Specialty Mental Health Services

Q2. Does staff claim travel and documentation time at whatever service function rate, e.g., Mental Health Service (MHS), Case Management, etc., of the service provided?
A2. Yes. Travel and documentation time must be linked to the service provided.

Q3. Can staff claim Medi-Cal for case management services provided while a beneficiary is in an IMD?
A3. FFP cannot be claimed if the beneficiary is between the ages of 22-64. Yes, if the beneficiary is 65 or older. Yes, if the beneficiary is under 21 and is a patient in a hospital or another accredited facility. Follow the specific restrictions indicated for each specific institution (or MH service) as indicated on the *ACBHCS Medi-Cal (M/C) Lock-out Grid*.
http://www.acbhcs.org/href_files/LockoutSituationsGrid_061517.pdf

Q4. Can staff claim Medi-Cal for transporting beneficiaries to mental health appointments as a specialty mental health service?
A4. No. Transportation is not reimbursable as a specialty mental health service.

Q5. Can staff claim Medi-Cal for a parenting group that includes parents whose children have open cases at the clinic?
A5. Yes, if the services are directed at the mental health needs of the children, rather than based upon the needs of the parents. In addition, there must be documentation in the child's chart to show the need for this activity.

Q6. 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?
A6. Time should be divided equally among the clients being represented. The time should be treated as if this were a group setting composed only of the clients being represented (the parents themselves would not count as group members). Only the time for clients who are Medi-Cal-eligible may be claimed as a Medi-Cal service. For example, a staff meets with three Medi-Cal-eligible clients, five parents of these three clients, and two parents of one Medi-Cal-eligible client who was not present for a total of ten people in a group setting for 120 minutes. Since four beneficiaries were represented, the time is divided by four, and 30 minutes is claimed for each client. If there were an additional client who was not Medi-Cal eligible and that client's parents, the time would be divided by five, and 24 minutes would be claimed for each Medi-Cal eligible client.

Q7. When a treatment group contains both Medi-Cal and non Medi-Cal clients, how is staff to divide the time? For example, if a group of six clients containing three Medi-Cal and three non-Medi-Cal clients lasts 120 minutes (group time plus documentation), how is the time divided? By three, or by six?
A7. If a provider is delivering services to a group composed of both Medi-Cal and non-Medi-Cal eligible individuals, and the rate is the same, the provider would prorate his or her time for all (6 in above example) individuals who participated.

Q8. Can Medi-Cal be claimed for assisting beneficiaries to obtain their medication by preparing an authorization request?
A8. Yes, Medi-Cal can be claimed for completing an authorization request for a prescription as it relates to the provision of medication support services. Only physicians, Nurse Practitioners, Physician Assistants, RNs, LVNs, psychiatric technicians, or pharmacists within their scopes of practice may provide medication support services.

Q9. Can staff claim Medi-Cal for photocopying, faxing, and other clerical type activities as specialty mental health services?

A9. No.

Q10. Can staff claim Medi-Cal for payee related activities?
A10. Medi-Cal cannot be claimed for time spent performing the fiscal responsibilities of a payee. For example, staff cannot claim Medi-Cal for time spent writing checks to pay the beneficiary's bills. However, it is possible to claim for payee related services when such activities are necessary to address impairment in an important area of life functioning. For example, staff can claim Medi-Cal for time spent providing training on money management skills.

Q11. Can staff claim Medi-Cal for telephone assessments?
A11. Yes. Assessments can be completed face-to-face or over the telephone. However, providers are strongly encouraged to complete face-to-face assessments when determining medical necessity.

Q12. How long can staff claim Medi-Cal for services provided after a beneficiary has died?
A12. All services claimed to Medi-Cal on behalf of a beneficiary must be provided to meet the mental health needs of that beneficiary. Therefore, Medi-Cal cannot be claimed for any services provided once the beneficiary has died. In addition, claims must be submitted in a timely fashion as specified in Title 9.

Q13. Can staff claim Medi-Cal for court related assessments, e.g., conservatorship investigations?
A13. No, if the assessment is completed per request of the court for a purpose other than determining medical necessity for Medi-Cal. For example, Medi-Cal cannot be claimed if a court-ordered assessment is narrowly defined for establishment of conservatorship and the MHP limits its assessment to this purpose.

Q14. What are the current 24-hour claiming limitations listed by service type?
A14. California Code of Regulations (CCR), Title 9, Chapter 11, Section 1840.366(b) specifies: "The maximum amount claimable for Crisis Psychotherapy (aka 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 specifies: "The maximum amount claimable for Medication Support Services in a 24-hour period is 4 hours."

Q15. Regarding medication support services, can staff claim Medi-Cal for medication support services in a group setting as long as the following conditions are met:
Time is prorated per CCR, Title 9, Chapter 11, Section 1840.316(a)(2), and
The medication support services provided meets the definition of medication support services in CCR, Title 9, Chapter 11, Section 1810.225, and
The service is provided by staff who are qualified to provide such services?
A15. Yes, as in the following 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.

Q16. Are there any special lockouts on claiming Medi-Cal while a beneficiary is in Rate Classification Level (RCL) 12-14 facilities (group homes that specialize in serving children with mental illness)?
A16. There are no special lockouts outside those listed in Title 9 (except for ICC/IHBS services) while a beneficiary resides in RCL 12-14 facilities because the RCL 12-14 rates do not include treatment services. The duplicate payment issues that exist when a beneficiary is in a 24-hour facility that is receiving reimbursement for treatment services do not exist when the beneficiary is in an RCL 12-14 facility.

Q17. Can Medi-Cal be claimed for travel time from one provider site to another provider site? How about from a staff person's residence to a provider site, or from a staff's home to a client's home?
A17. To claim Medi-Cal, travel time must be from a provider site to an off-site location(s) where Medi-Cal specialty mental health services are delivered. Therefore, Medi-Cal cannot be claimed for travel between provider sites or from a staff member's residence to a provider site.
NOTE: A "provider site" is defined as a site with a provider number, including affiliated satellite and school site operations.

Q18. How long and what types of services can be claimed to Medi-Cal prior to a determination of medical necessity?
A18. In an urgent, crisis, or emergency situation, the MHP can/should provide whatever services are needed prior to establishing that all medical necessity criteria are met. If not an urgent, crisis, or emergency situation, the MHP should only claim those assessment services necessary to establish medical necessity.

Alameda has established a maximum 30 day intake period (from the Episode Opening Date – EOD) during which time the provider is to establish medical necessity and complete the MH Assessment with Diagnosis (unless other specified timeframe in the *ACBHCS Clinical Documentation Manual*). Up to 60 days (from EOD) is allowed to set up the client plan, and coordinate the arrangement of necessary services (unless other specified timeframe in the *ACBHCS Clinical Documentation Manual*). *However, the intake period is not exempt from the medical necessity requirements for claiming Medi-Cal (for example once it is determined that there is not an Included Diagnosis—or any other aspect of Medi-Cal medical necessity is not met—there may be no further claiming, even for MH Assessment or Plan Development).*

Q19. How does staff claim time when services with two different rates are provided during the course of a client session, e.g., 30 minutes of mental health services and 30 minutes of case management? Does the staff claim the whole time to the dominant service provided, or claims 30 minutes to mental health services and 30 minutes to case management?
Can staff write one progress note and break out the claim by each service, or must a separate progress note be written for each service?
A19. In the above situation, staff should claim for each service separately or claim the entire time to the lower cost center, e.g., case management. Staff may write two separate progress notes or write one progress note *that clearly delineates the time spent providing each service.*

- Example One: One note for 60" Case Management written and claimed with delineation in body of PN that 30" was spent on MH Services (such as Individual Therapy) and 30" was spent of Case Management.
- Example Two: Two notes written and claimed. One for 30" Case Management and one note for 30" MH Service (such as Ind Therapy).

Q20. When can *Medi-Cal* be claimed for treating undocumented individuals?
A20. The MHP needs to deliver services to beneficiaries who are undocumented individuals based on what is covered by the beneficiaries' aid category. Undocumented individuals are eligible for aid categories that cover emergency and/or pregnancy services only.
Title 9, California Code of Regulations (CCR), Section 1810.216 says:
"'Emergency Psychiatric Condition' means a condition that meets the criteria in Section 1820.205 when the beneficiary with the condition, due to a mental disorder, is a danger to self or others, or immediately unable to provide for or

utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services."
What this means is that only emergency psychiatric inpatient hospital services and related psychiatric inpatient hospital professional services are covered for Medi-Cal beneficiaries who are only covered for emergency services. Crisis intervention and crisis stabilization are not emergency services under the Medi-Cal managed mental health care program.
Pregnancy-related services, when covered, are broader than emergency services. These services involve treatment of a mental illness that might affect the outcome of the pregnancy.
A Provider's contract may include the provision of non-Medi-Cal services to undocumented individuals, or others without Medi-Cal.

Q21. If a patient is admitted to an acute care setting for a medical condition, what specialty mental health services are eligible for Medi-Cal?
A21. CCR, Title 9, Section 1840.215 and Sections 1840.360 through 1840.374 only address lock-out requirements for specialty mental health services. There is nothing in the regulations that prohibits claiming Medi-Cal for the provision of medically necessary specialty mental health services while a beneficiary is on a medical unit. See *ACBHCS Medi-Cal Lock-out Grid*.

Q22. Can Medi-Cal be claimed for administrative hospital days if Medi-Cal was not claimed for the days of acute status? For example, a patient who otherwise meets medical necessity criteria but is ineligible for Medi-Cal because of his/her legal status, e.g., in jail custody. The court later releases him/her, but the patient remains in the hospital pending suitable placement.
A22. Yes, as long as medical necessity for acute psychiatric inpatient hospital services had been established at some point during the patient's stay in the hospital and the administrative days meet criteria specified in CCR, Title 9, Section 1820.220(j)(5).

Q23. What are the rules around claiming Medi-Cal for services provided by students, volunteers, and paid consumers?
A23. Generally: 1) A "student" (aka trainee) is someone who is in school in a social work, counseling, or related school placement program at a provider site and includes both undergraduate and graduate students. 2) A "volunteer" is someone who is not "employed" by the provider, for example, a person accumulating qualifying hours to become licensed, and works without pay. 3) A "paid

consumer" is someone who is a consumer and who is employed by the provider, typically to provide peer support and interaction to the provider's clients.
As long as all Medi-Cal requirements and any supervision and scope of practice requirements are met, providers may claim for Medi-Cal services provided by students, volunteers, and paid consumers (all additional provider credentialing requirements remain the same.) See *ACBHCS Medi-Cal Lock-out Grid*.

Q24. What are the requirements of diagnoses entered into InSyst and how does this differ from documenting the diagnoses in the client's clinical record?
A24. InSyst is part of the county and state's Medi-Cal billing system, diagnoses entered into InSyst should relate to claims made to Medi-Cal. Only select mental health diagnoses approved by DHCS may be treated under Medi-Cal services and are also known as *Included Diagnoses*. Only treatment for Included diagnoses may be claimed to Medi-Cal and as such only those diagnoses are required to be inputted in to InSyst. Additional (non-treated) diagnoses may be entered into InSyst, but some may not be allowed. SMHS Inpatient, SMHS Outpatient, and SUD services have different *Included Diagnoses* lists that can be found on the BHCS Provider website. Providers must use the appropriate *Included* list for their type of services. Please see the Quality Assurance section of the ACBHCS Provider Website for the M/C Included Diagnoses Lists. See SMHS FAQ, Section I. Assessment / Diagnoses Q2 for diagnoses charting requirements.
http://www.acbhcs.org/providers/QA/audit.htm

- *Diagnoses Lists and Crosswalks:*
  1. *ACBHCS Mental Inpatient Medi-Cal Included Dx List Alpha by DSM-5 Name*
  2. *ACBHCS DSM-IV to DSM-5 Mental Health Included Dx Crosswalk by DSM-5 Chapters*
  3. *ACBHS Mental Inpatient Medi-Cal Included Dx List Numeric by ICD-10 Codes*
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  5. *ACBHCS General Medical Codes*
  6. *ACBHCS Psychosocial Dx List Alpha by DSM-5 Name*
  7. *ACBHCS Psychosocial Dx List Numeric By ICD-10 Code*

VI. Grievances and Appeals

Q1. What is the definition of "grievance"? If there are no more "informal complaints," what qualifies as an issue that must follow the resolution process, and

what does not? When does a verbal 'bad hair day' remark transition into a verbal grievance? How do we decide if little gripes have to follow a formal grievance process?

A1. Per Title 42, CFR, Section 438.400(b), "grievance" means an expression of dissatisfaction about any matter other than an "action." If a beneficiary decides to use the MHP process to file a grievance, i.e., telling the designated grievance staff person, filling out a form, etc. for a minor issue then the provider needs to follow the grievance process. If the beneficiary makes a remark to a receptionist, clinician, etc., in passing, but does not want to pursue further action, then they are not required to do so. Or, if a beneficiary makes a comment directly to their clinician, or another MHP staff person, but just wants to "vent," that beneficiary does not have to file a grievance with the MHP. In this example, the clinician, or other MHP staff person, should take the opportunity to remind the beneficiary of the available problem resolution processes.

VII. Informing Materials

Q1. Must providers utilize the ACBHCS developed Informing Materials.

A1. Yes, however, providers may add additional documents to the Informing Materials packet.

Q2. What Scope of Practice must staff hold in order to explain (and answer questions regarding) the ACBHCS required Informing Materials Packet?

A2a. Any staff may explain and answer questions with the proper training, knowledge and experience for the following items in 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; and Maintaining a Welcoming & Safe Place (not a required informing material). The Progress Note must document this discussion and be signed by the provider.

A2b. Only staff whose Scope of Practice includes conducting MH Assessments may explain and answer questions regarding: Consent for Services; Confidentiality & Privacy statement (Duty to Report); and the Notice of Privacy Practices (HIPAA/HITECH)**.** This is limited to Graduate MH Students/Trainees and (Board Licensed, Waivered or Registered) LPHA's. As this discussion may elicit sensitive clinical concerns (such as abuse or neglect), it must be held in a private confidential setting. The Progress Note must document this discussion and be signed by staff with these credentials.

Informing Materials Resources:
http://www.acbhcs.org/providers/QA/General/informing.htm

VIII. Medicare-Medi-Cal Concurrent Billing

Q1. What constitutes a service provided by telephone and how is billing coded?
A1. Services provided by telephone differ from telemedicine services. Telemedicine benefits are Medicare reimbursable when provided from a clinic through interactive voice and visual interface between the provider and the client and when provided in specific, eligible geographic regions. Services provided via telemedicine should be claimed to Medicare prior to Medi-Cal unless another exception to prior Medicare claiming exists.
Specialty mental health services provided over the telephone are not Medicare reimbursable and should be billed directly to Medi-Cal. When a service is delivered by telephone, the appropriate place of service code should be indicated as "telephone".

Q2. How is place of service "03" (School) defined?
Q2. A facility whose primary purpose is education.

Q3. How is place of service "15" (Mobile Unit) defined?
A3. A facility/unit that moves from place-to-place and equipped to provide preventive, screening, diagnostic, and/or treatment services.

Q4. How should the service activity "Plan Development" under "Mental Health Services" be billed for Medi-Medi claims?
A4. Plan Development is a service activity under Mental Health Services that is not Medicare reimbursable regardless of where it is provided, or who provides it. When claiming the service activity Plan Development under Mental Health Services bill Medi-Cal directly for Medi-Medi clients.

Q5. How should the service activities "Assessment", "Therapy", and "Collateral" under "Mental Health Services" be billed for Medi-Medi claims?
A5. These must be claimed to Medicare prior to Medi-Cal, unless an exception to Medicare billing exists (for example, the service is provided over the telephone or in the community, it is provided by a non-Medicare reimbursable provider, or in a non-Medicare reimbursable place of service).

IX. Scope of Practice

Q1. Regarding the AA degree referenced in Title 9, CCR, Section 630, defining a Mental Health Rehabilitation Specialist, can two years of college be substituted for the AA degree?
A1. Receipt of an AA degree is an absolute. Two years of college cannot substitute for it. Title 9, CCR, Section 630, reads: "A mental health rehabilitation specialist shall be an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years of post-associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years' experience in a mental health setting." See Table #1 below.

TABLE 1: MHRS REQUIREMENTS	
Educational Degree (any subject)	*Experience (specialist in field of physical restoration, social adjustment or vocational adjustment in a MH Setting)*
AA/AS	6 years
BA/BS	4 years
MS/MA or PhD/PsyD and not Licensed/Waivered/Registered	2 years

See *ACBHCS Scope of Practice Grid*.

X. Therapeutic Behavioral Services

Q1. What are the qualifications for a TBS provider?
A1. TBS may be provided by a Licensed Practitioner of the Healing Arts (LPHA), or staff that is under the direction of a LPHA to provide TBS. The TBS Clinician is an LPHA and is responsible for the treatment plan establishing goals and is the Medi-Cal provider. The TBS Coach is under the direct supervision of the TBS Clinician and implements the TBS Treatment plan with the approval/supervision of the TBS Clinician.

Q2. Where can the training information and manuals mentioned in DMH Information Notice 08-38 be found? Who do we contact to receive these materials and the technical assistance needed to implement the new requirements?

A2. 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 on the website below. In addition, subscribe to TBS information on the DMH website for up to date details on the training materials as well as all other TBS information.
http://www.dhcs.ca.gov/services/mh/Pages/EPSDT.aspx

Q3. Who can provide Specialty Mental Health Services to children receiving TBS?
A3. A provider is defined in the California Code of Regulations (CCR), 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 specialty mental health services 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.

Q4. Can TBS be a "stand alone" mental health service or does the client need to have an open mental health case with the MHP?
A4. TBS can never be a "stand alone" mental health service. TBS is considered short term and supplemental to other Specialty Mental Health Services. Specialty Mental Health Services 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. http://www.dhcs.ca.gov/services/mh/Pages/EPSDT.aspx

Q5. Are there TBS Manuals?
A5. Yes: Therapeutic Behavioral Services Coordination of Care Best Practices Manual 2.0 - 12/21/2010 & Therapeutic Behavioral Services (TBS) Documentation Manual 2.0: To support the implementation of the Court's approved Nine Point Plan, the Department developed the TBS Documentation Manual to guide counties and other key stakeholders on how to document and claim TBS appropriately.

XI. Day Treatment [Day Rehabilitation (DR) or Day Treatment Intensive (DTI)]

Q1. Assessment window: if a child is admitted to day treatment without a recent assessment, is an assessment "window" available to establish the service necessity, as in Coordinated Care?
A1. Providers are required to seek initial authorization for day treatment services and prior authorization for day treatment services that exceed five days per week.

Q2. Staff available to the milieu: is this requirement met if staff is in the milieu room but working individually with a child? On site (in another room) but working with one child or awaiting a need for their intervention?
A2. Day treatment staff must be available where and when day treatment therapeutic milieu is being provided and available to respond to the needs of the group. At least one staff person must be available to the group in the therapeutic milieu. Staff in the milieu room working with an individual beneficiary would be considered staff available to the milieu. Staffing ratios must be maintained. Staff on site, but in another room working with one client or waiting for the need for intervention would not be considered staff available to the milieu.
If a beneficiary requires such a high degree of one-to-one interaction that staffing ratios are jeopardized or that other day treatment beneficiaries do not have access to the staff, the day treatment program may not be appropriate to meet the needs of the beneficiary and other interventions should be considered. The provision of day treatment is an interactive process. Day treatment staff should not be simply awaiting a need to intervene. Staff should be actively involved the entire time the day treatment program is in operation providing therapeutic interventions to the group. It is reasonable to anticipate that one beneficiary might require additional attention at some time; however, the day treatment staff should use the milieu environment to support the intervention. For example: One beneficiary habitually interferes with other beneficiaries in a group process. The day treatment staff would use the input of the other group members to identify the behavior, to identify why the behavior is problematic and to develop interventions.

Q3. Continuous hours of operation: if staff is fully integrated into a classroom during academic instruction, may the school day hours be counted as part of the continuous hours? If so, must staff be present in the classroom to be counted as fully integrated?
A3. The hours of the day treatment milieu must be continuous and are not tied to the hours of the setting in which they are provided (e.g., school). The day treatment

milieu may operate for a continuous period of time during the school day, but may not be provided in discontinuous "blocks" of time, e.g., two hours in the morning, two hours in the afternoon and one hour after school. The day treatment milieu establishes the hours of operation and must exceed four hours per day for full day programs and be at least three hours per day for half-day programs.
In addition to required hours of operation, full-day programs require an average of three treatment hours and half-day program require an average of two treatment hours per day in the day treatment milieu. The community meeting time is not counted in the required treatment hours, but may be a part of the continuous hours of operation/therapeutic milieu or may be separate. (If the community meeting time is not continuous with the therapeutic milieu, the meeting time would not count toward the required hours of operation for a full-day or half day program.) If day treatment is taking place in a school setting, day treatment staff must be present during day treatment time. In cases where staff members work for both a day treatment program and another program (e.g., school), there must be a clear audit trail which documents that staff time and activities are exclusively allocated to one program at a time. The staff must only be counted in one staffing ratio at a time, i.e., while the staff is working in the day treatment program, the staff may not be counted in the school program staffing ratio and vice-versa. See Table 2 below.

Q4. Length of stay: is there any sort of expectation about how long a client could/should remain in day treatment?
A4. Clinical decisions and determinations to continue or discontinue day treatment or any other specialty mental health service must be based on the individual treatment needs of the beneficiary. Providers are responsible for monitoring beneficiaries' progress in day treatment to determine when client plan goals have been met and to determine when day treatment should be continued, reduced, or terminated.

TABLE 2: DAY TREATMENT (DR & DTI) HOURS		
Type of Hours	*Half Day Program*	*Full Day Program*
Minimum hours of Operation (continuous therapeutic milieu)	3 hours	> than 4 hours
Minimum average daily hours of service components (psychotherapy, process groups, skill building groups, and adjunctive therapies groups) must be made available	2 hours	3 hours

Q5. Minimum attendance: must a child be in the milieu for over 50% of the day for billing to be allowed? Or, could some of the time be spent in individual services apart from the milieu but not separately billed, or in transitioning to a mainstream classroom?
A5. Beneficiaries are expected to be present in the day treatment program for all scheduled hours of operation of the day treatment program. When a beneficiary is unavoidably absent for some part of the hours of operation, day treatment for an individual beneficiary will only be reimbursed if the beneficiary is present for at least 50% of the hours of the scheduled hours of that day. Individual services may be part of the day treatment program, provided the minimum day treatment requirements are met for the beneficiary. There are no exceptions to these requirements for children being transitioned to a mainstream classroom.

Q6. Authorization: must a number of service units be requested for authorization, or only the type of service?
A6. Day treatment authorizations must address the total number of days for which the service is authorized. The number of days per week as well as the length of calendar time must be specified. Authorizations which exceed five days a week must be prior authorized by ACBHCS. Mental health services as defined in Title 9, California Code of Regulations (CCR), Section 1810.227, excluding services to treat emergency and urgent conditions and therapeutic behavioral services, provided to a beneficiary on the same day as day treatment must be prior authorized by the MHP. ACBHCS must establish that the additional services are medically necessary considering that the beneficiary is also receiving day treatment. The authorization period for the mental health services (as defined above) must identify when reauthorization, if necessary, will be required and cannot exceed the timeframes for authorization of the day treatment program. Generally, authorization of the type of service and the number of units within the authorization period would be the most effective way to achieve these goals. ACBHCS may use alternate methods, as long as these goals are met.

Q7. Activities outside program hours: how can the required contact with caregivers, travel, documentation, etc. be distinguished from non-day treatment activities such as collateral contacts?
A7. The caregiver contact requirement specific to day treatment is focused on the contact being related to the beneficiary's progress in day treatment and to support the role of the caregiver in supporting the beneficiary's treatment goals.

Documentation of the contact should be included in the day treatment documentation.
Collateral contacts that are not part of day treatment must be documented in accordance with the documentation requirements of the specific specialty mental health service being provided to the beneficiary. If the collateral contacts are delivered as mental health services that require prior authorization, prior authorization must be obtained. If day treatment staff also delivers collateral or direct services that are not part of the day treatment program, the provider must establish fiscal tracking mechanisms that maintain a clear distinction between staff time and related resources attributable to the day treatment program and staff time and related resources attributable to other services. For example, the staff may be required to report the actual minutes/hours in each day spent on each type of service.

Q8. Under what conditions can classroom time be counted towards day treatment time?
A8. Academic educational activities cannot be counted towards day treatment time.

Q9. Doesn't the authorization by the ACBHCS process usurp the role of the IEP which, by federal and state statute, determines the services a special education eligible child will receive?
A9. No, the authorization by the MHP described in the MHP Contract relates only to Medi-Cal payment for Medi-Cal eligible children. The Individualized Education Plan (IEP) Team process is independent of the Medi-Cal authorization process. As long as the IEP identifies the need for a mental health service and county mental health is the appropriate resource and concurs with the identified need, then county mental health is responsible for ensuring the provision of the identified service.

Q10. What would be an example of a typical day of three continuous hours of group work for young kids with impulse control problems, rapid mood fluctuations, hyperactivity, and frequent need for individual attention or redirection?
A10. The therapeutic milieu components can be provided while the children are engaged in various activities, as long as the components are made available for the required time period during the course of the day treatment.

Q11: Can providers charge a fee to Medi-Cal beneficiaries for meals served at day

rehabilitation or day treatment intensive program sites during the hours that the program operates?

A11: Providers may not bill Medi-Cal beneficiaries or their conservators or otherwise require Medi-Cal beneficiaries to pay a fee for meals served during day rehabilitation or day treatment intensive program hours of operation.

XII. Client Plans

Q1: When a young child is in Foster Care, and has a Child Welfare Worker as well as Foster parents and Biological parents is there some kind of "Practice Guideline" regarding who signs the Client Plan?

A1: Since the Client Plan is not a legal document and belongs to the client, the client signs the Plan. (This is different from informed consent.) Even a young child can show understanding and ownership of the Plan. The child client can sign with their name, a scribble, etc. if they understand that signing it shows that the Plan belongs to them.

A statement written by the clinician documenting why it is clinically inappropriate to obtain client's signature is sufficient, especially for preverbal children. However, if treatment includes child-parent work then it could be appropriate to obtain the signature of the parent involved in treatment. Additionally, if a clinician finds it clinically appropriate to review the Plan with foster parents or bio parents, then their signatures can be obtained, but are not required.