alameda county behavioral health

MENTAL HEALTH & SUBSTANCE USE SERVICES

FREQUENTLY ASKED QUESTIONS: CALIFORNIA ADVANCING & INNOVATING MEDI-CAL (FAQs FOR CALAIM)

Alameda County Behavioral Health Care Services
Quality Assurance Team

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MENTAL HEALTH & SUBSTANCE USE SERVICES

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General

1. **What is the timeframe for roll out of the multiple CalAIM Behavioral Health initiatives?**

   The calendar noted below shows the expected go-live dates for each of the policies. Since this is a significant transition, the State is not expecting that all changes are implemented immediately. The expectation is that the Counties and providers make their best effort to implement the new requirements by the go-live date but it is understood that change is a process and that all requirements may not be in place by that date. For example, while Problem Lists must be created for new clients who are admitted on or after 7/1/2022, it may take longer to update the clinical notes for existing clients.

Policy	Go-Live Date
Criteria for Specialty Mental Health Services	January 2022
Drug Medi-Cal Organized Delivery System 2022-2026	January 2022
Drug Medi-Cal ASAM Level of Care Determination	January 2022
Updated Annual Review Protocol and Reasons for Recoupment FY 2021-2022	January 2022
Documentation Redesign for Substance Use Disorder & Specialty Mental Health Services	July 2022
Co-Occurring Treatment	July 2022
No Wrong Door	July 2022
Updated Annual Review Protocol and Reasons for Recoupment FY 2022-2023	October 2022
Standardized Screening & Transition Tools	January 2023
Behavioral Health CPT Coding Transition	July 2023
County Behavioral Health Plans Transition to Fee-for-Service and Intergovernmental Transfers	July 2023
Administrative Behavioral Health Integration	January 2027

2. **What training and resources will be provided to providers to assist with these practice changes?** *Updated 7/18/22*

   California Mental Health Services Authority (CalMHSA) is a Joint Powers of Authority that provides administrative and fiscal services in support of Behavioral Health Departments. CalMHSA, on behalf of the counties, has assumed scopes of work to support the statewide implementation of CalAIM behavioral health initiatives. CalMHSA's scope of work includes development of required Policies and Procedures, Communication Plans and Materials, Documentation Guides, and Web-based Training Videos. 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.

   Below are some of the helpful resources that are published on the CalMHSA's CalAIM webpage:

   - **Clinical Documentation manuals**: CalMHSA has published a number of manuals for both SMHS and DMC-ODS providers. These manuals are updated by CalMHSA as

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additional clarification is received from the State so it is important to use the CalMHSA CalAIM webpage to access the most recent version of these manuals.

- **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 (LMS).

Additionally, a number of resources have been offered to providers. Most are in the ACBH Quality Assurance (QA) section of the Provider Website under Memos. As policies are created by CalMHSA, they are posted on the Policy and Procedure page of the Provider Website. As of June 27, 2022, the following two policies have been published : 1) Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026, 2) Criteria for Beneficiary Access to Specialty Mental Health Services (SMHS), Medical Necessity and Other Coverage Requirements

ACBH will continue to share information through memos, Brown Bag meetings and Town Halls. If you have not been receiving our memos, or do not have the Brown Bag meeting invitations on your calendar, please reach out to QATA@acgov.org to provide your contact information.

3. **Can we have an extension to the 7/31/22 training deadline for our clinicians who provide school-based services and are on summer recess, not returning until August?** *Added 7/18/22*

   For providers who work at school sites, QA has extended the deadline for completing the CalAIM Training videos to August 31, 2022. Agencies are responsible for tracking and ensuring completion of the trainings by this date.

4. **May staff who are out on leave have an extension for completing the required CalMHSA CalAIM training videos?** *Added 7/18/22*

   Yes, QA will allow an extension for people who are on leave. Agencies are responsible for tracking and ensuring completion when employees return from leave.

5. **Are fee-for-service (FFS)/private practice providers required to complete the CalMHSA CalAIM training videos?** *Added 7/18/22*

   FFS providers are required to complete the CalMHSA CalAIM Overview training video by July 31, 2022s. Other training requirements will be communicated to FFS providers in upcoming memos.

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6. **While there is no requirement to retrospectively change client records, should Community Based Organizations (CBOs) incorporate the new criteria in closing / discharge summaries? If so, can you outline what specifically should change?**

   Yes. The Clinical Documentation Manual for Outpatient Specialty Mental Health Services, clarifies what is required as part of a successful discharge discussion. Specifically, "A successful discharge discussion includes a review of how the person can continue to receive any necessary support and how those needs may be addressed post-discharge from the program. Information contained in discharge plans and shared with the person in care includes how the person's needs may be addressed, information on prescribed medications, the type of care the person is expected to receive and by whom, information on crisis supports, and available community services, to name a few. Additionally, to document the needs and strengths of the individual as they are leaving care, providers who work with individuals under age 21 are also required to complete a CANS and PSC-35 at discharge."

7. **Will Current Procedural Terminology (CPT) codes be required for a July 1, 2022, start date or will ACBH maintain the current system for providers and cross-walk service types and times into CPT codes?** *Updated 7/18/22*

   ACBH is replacing its current Practice Management System (InSYST) with a new system called SmartCare. CPT code adoption is not scheduled until July 1, 2023 when ACBH transitions to SmartCare. ACBH Benefits and Billing Support Unit is leading this transition and will provide additional information as we approach the SmartCare implementation date.

8. **How does ACBH anticipate introducing International Classification of Diseases and Related Health Problems (ICD 10) codes? And will there be a way to limit them by level of services offered in order to minimize errors?**

   ACBH is currently in discussions regarding this topic and how the changes to diagnosis requirements will be implemented in our systems. ACBH is in the process of transitioning from InSyst to SmartCare. Because of this transition, there are limitations on updates to InSyst.

   Due to the unique needs of DMC-ODS, effective 6/1/22, codes Z55-Z65 have been added to the Substance Use Disorder (SUD) environment for Clinician Gateway (CG) and InSYST. The Client and Service Information (CSI) reporting requirements connected to SMHS, make this transition more difficult in the mental health environment. That change is expected to occur with the launch of SmartCare in July 2023. Until that time, SMHS providers can continue to use Z03.89, as appropriate.

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9. **Will the Clinical Quality Review Team (CQRT) checklist be revised? Will there be any process changes?** *Updated 12/30/22*

   Yes, ACBH, in partnership with the Behavioral Health (BH) Collaborative has published an updated CQRT checklist and procedures. Please see ACBH memo on the Provider Website for more details.

10. **How will the QA, IT, Finance, and Contracts departments integrate decisions and changes?**

    Many of the new changes have cross-departmental impact. ACBH is actively collaborating across departments, and with internal and external stakeholders, to implement the changes in the most efficient and effective way possible.

11. **Do the Behavioral Health Information Notices (BHINs) and ACBH memos supersede any contracts that are contrary to those directions?**

    ACBH contracts stipulate that contractors providing Medi-Cal services shall provide and maintain clinical documentation that complies with regulatory requirements and with ACBH Clinical Documentation Standards as specified in the ACBH MH Clinical Documentation Standards Manual for Master Contract Providers (also applicable for Services as Needed providers) or ACBH DMC-ODS Practice Guidelines and Clinical Process Standards. Updates and/or clarifications to clinical documentation standards may also occur via ACBH QA memos and training materials.

Disallowances and Recoupment

12. **Considering new standards for fraud, waste and abuse, is there a window of audit grace?** *Updated 12/30/22*

    DHCS continues to hold counties responsible for all monitoring and audit requirements.

    The federal standards for fraud, waste, and abuse have not changed, however DHCS guidance on disallowance and recoupment is evolving. DHCS has issued a SMHS Reasons for Recoupment for FY 21-22 and a DRAFT of the SMHS Reasons for Recoupment for FY 22-23. ACBH will be following the DHCS guidance for audits.

13. **Will a service be disallowed or billing recouped, if it is not reflected in the Care Plan?**

    No. Per DHCS, clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery services are no longer excluded/disallowed if: 1) Services

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were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process; 2) The prevention, screening, assessment, treatment, or recovery services are not included in an individual treatment plan; 3) The beneficiary has a co-occurring substance use disorder.

14. **If treatment services can be provided before the Assessment and Care Plan have been completed, can they also be provided in periods between authorization? Example: If a cycle ends in December but the new Assessment and Care Plan aren't completed until January 5th, would the services between December 31st and January 5th be disallowed if not waste, fraud, or abuse?** *Added 7/18/22*

    Per the new guidance, clinically appropriate and covered MH prevention, screening, assessment, treatment, or recovery services are no longer excluded if the services are not included in an individualized Care Plan. Disallowances are based on fraud, waste or abuse. Additionally, ACBH is following the State's guidance regarding timeliness requirements and not setting timeframes for completion of initial and annual assessments. Assessments should be updated as clinically appropriate and consistent with best practice guidelines.

15. **Will future ACBH audits only look at requirements when non-compliance may result in disallowance?** *Updated 12/30/22*

    ACBH is still responsible for monitoring providers to ensure compliance with all laws, regulations, and requirements. ACBH will be recouping non-compliant items based on the DHCS recoupment reasons:

    - SMHS Reasons for Recoupment for FY 21-22
    - SMHS Reasons for Recoupment for FY 22-23 (DRAFT)

No Wrong Door

16. **Are we at risk of having the service disallowed if we mention SUD treatment in our Mental Health (MH) documentation, or MH treatment in our SUD documentation?**

    No, with the new guidance, co-occurring conditions are covered. The guidance allows for more flexibility for providers, allowing them to treat individuals holistically.

17. **If an individual contacts the Access Line requesting services, do we have to treat them even if we do not think they will meet criteria to access SMHS?** *Updated 7/18/22*

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No. No Wrong Door does not mean a Mental Health Plan (MHP) has to serve every individual who reaches out for services. Until the screening and transition tools go live, MHPs should continue to follow current screening procedures to determine if an individual will be served by the MHP or if they should be referred to the Managed Care Plan (MCP).

No Wrong Door does mean that Medi-Cal providers will assist beneficiaries regardless of which delivery system they request services. If during the assessment process it is determined a beneficiary would benefit from a referral to a different type of provider, the provider of first contact may assist the beneficiary in transitioning to or coordinating care with a more appropriate provider based on the assessed needs.

18. **Do SMHS providers now have to treat substance use disorders and do SUD providers now have to treat MH disorders?**

    Providers are not being required to work out of their scope and abilities and should continue to provide services within their scope of practice and specialty. There is now greater flexibility to support an individual with both conditions.

19. **The BHIN indicates that a beneficiary under 21 years of age, is eligible for services through the MHP if they have "*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 a suspected mental health disorder. Does this mean that CBOs can serve youth with mild to moderate mental health needs through their ACBH contract?**

    No changes have been made to a CBO's ability to serve mild-moderate beneficiaries under its ACBH contract. CBOs will continue to serve beneficiaries categorized as moderate-severe and should connect mild-moderate beneficiaries to an appropriate provider. See BHIN 22-011 for details.

20. **How would "No Wrong Door" policy play out for clients whose Medi-Cal has lapsed midway of services or is yet to be transferred over to Alameda from another County?** *Added 7/18/22*

    "No Wrong Door" does not address lapses in benefit eligibility. The goal of no wrong door is to remove barriers to care for beneficiaries who have active Medi-Cal benefits. Questions related to Medi-Cal eligibility should continue to be directed to the Billing and Benefits Department.

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21. Can beneficiaries receive both SMHS and DMC-ODS treatment simultaneously? *Added 12/30/22*

Yes, as long as the services are not duplicative or wasteful. When a beneficiary is being treated in both systems, the active service providers must coordinate care as much as is clinically necessary to meet the treatment needs of the beneficiary, to avoid duplication of services, and to ensure that treatment is not working at cross purposes. When other services are known, the treatment record must include documentation of this collaboration, or attempts at collaboration. Note that to coordinate care with a SUD provider, per 42 CFR, Part 2 – Confidentiality of Substance Use Disorder Patient Records, ROIs are required.

Access Criteria and Medical Necessity

22. Does the BHIN's new medical necessity language replace the language in the previous requirements, rather than augmenting it? Do any previous medical necessity elements remain (e.g., "risk of not developing as individually appropriate" is removed, the previous definition of "ameliorate" is replaced with the new language, etc.)?

The new medical necessity language replaces previous medical necessity language and required elements. See BHIN 21-073 for more information

23. How can medical necessity be met without a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic condition? Since a diagnosis is no longer required for access to services, how will the assessment be completed with a Z code? Will functional impairment be sufficient?

DHCS has introduced a new concept called Access Criteria that aims to remove unnecessary barriers to care by allowing treatment to begin prior to diagnosis, in cases where a diagnosis cannot be readily established. With the introduction of this concept, a diagnosis is no longer a prerequisite for accessing needed SMHS or DMC-ODS services. Services rendered in good faith are reimbursable prior to the determination of an official diagnosis.

Access Criteria is different from Medical Necessity. It looks at whether the individual is eligible to receive services, while Medical Necessity looks at whether the service provided is clinically appropriate to address the individual's condition.

Details related to Access Criteria and Medical Necessity can be found in BHIN 21-073 for SMHS and BHIN 21-075 for DMC-ODS.

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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 accepted to allow for billing and the start of a Problem List. DHCS has noted that there is no need for progress notes to demonstrate full medical necessity in each note, but a comprehensive up-to-date assessment and problem list is sufficient to meet these requirements. Clinically assessing a beneficiary's functional impairments is appropriate and should be part of an assessment.

The 40 minute training video titled CalAIM Overview published by CalMHSA provides additional details and a helpful vignette to demonstrate the new process. To access this training, you must first create an account on Learning Management System (LMS). Check this website frequently, as additional training videos will be posted in the coming weeks.

24. Has "Good Faith" been defined? *Added 7/18/22*

The State has not provided a definition; however, we believe that when the State speaks of providing services in "good faith", they mean that the provider, based on their clinical judgement and experience, believes that the beneficiary meets access criteria and can benefit from the clinical services being provided.

25. Can CBOs stop using the Brief Screening Tool given the access criteria updates?

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. CBOs need to continue to have screening procedures in place to determine if an individual will be served by the MHP or if they should be referred to the MCP.

ACBH has developed a Behavioral Health Screening tool for Outpatient Services for SMHS, and has made it available for optional use for outpatient mental health services until the standard tools become available. For DMC-ODS, an abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services.

26. DHCS has indicated that further guidance is forthcoming on state-approved trauma screening tools, but until then how can providers assess for the presence of trauma even when a child is not homeless or juvenile justice involved?

In BHIN 21-073, DHCS identified the following options: " The Pediatric ACES and Related Life-Events Screener (PEARLS) tool is one example of a standard way of measuring trauma for children and adolescents through age 19. The ACE Questionnaire is one example of a standard

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way of measuring trauma for adults beginning at age 18. DHCS will explore the approval process and standards for trauma screening tools for beneficiaries under 21 years of age through continued stakeholder engagement. MHPs are not required to implement these tools until DHCS issues additional guidance regarding approved trauma screening tool(s) for the purposes of SMHS access criteria."

27. Is someone who is coming into a recovery residence considered homeless? *Added 7/18/22*

A beneficiary's living situation prior to admission to a SUD Recovery Residence determines this status. While many individuals who are admitted to recovery residences may be homeless or have a history of homelessness, being homeless is not a prerequisite for admission into a recovery residence.

Unless otherwise noted, Medi-Cal services follow the definition of homelessness established in section 11434a of the federal McKinney-Vento Homeless Assistance Act. Specifically, this includes (A) individuals who lack a fixed, regular, and adequate nighttime residence and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

28. What if someone presents with a SUD diagnosis at the beginning of treatment? What guidance can be provided regarding how co-occurring disorders should be addressed?

The new guidance allows providers to treat beneficiaries when there are co-occurring mental health and substance use issues. It states:

"A clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service is no longer excluded if:

- Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process;

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- The prevention, screening, assessment, treatment, or recovery service is not included in an individual treatment plan;
- The beneficiary has a co-occurring substance use disorder."

If a beneficiary is assessed to have a primary SUD condition, they should be referred to the SUD system of care. The primary focus of treatment within SMHS remains the mental health disorder, while in DMC-ODS it is the substance use disorder.

More information related to the No Wrong Door policy can be found in BHIN 22-011.

29. **For beneficiaries presenting with co-occurring SUD and MH disorders, which diagnoses should be used for claiming purposes?** *Updated 7/18/22*

Use the diagnosis most appropriate for treatment in that system. Beneficiaries with co-occurring SUD and MH diagnoses can be treated simultaneously in both the SMHS and DMC-ODS systems. In SMHS, the primary focus of treatment is the MH condition, in DMC-ODS the SUD condition is the primary focus of treatment. The primary diagnosis should be relevant to the system of care (e.g., an MH primary diagnosis for SMHS and a SUD primary diagnosis for DMC-ODS).

30. **Is there a plan to change the Progress Note Templates in CG?** *Added 7/18/22*

The templates noted below were updated in CG effective 7/1/22. Please refer to the ACBH Providers Website and the Clinicians Gateway (CG) Template Updates memo. Providers will be notified as there are more changes to CG templates.

Providers Impacted	Template Name	Change Detail
SMHS and DMC-ODS	Problem List	New
DMC-ODS Residential Providers	Service Note Daily RES	Updated
DMC-ODS WM Providers	Service Note Daily WM RES	Updated
DMC-ODS Outpatient Providers	Progress note Single Service	Updated

Assessment

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31. **All providers, including non-licensed clinical staff are now able to use ICD-10 codes Z55 to Z65 during the assessment period prior to diagnosis. Where can we find information about these codes?** *Added 7/18/22*

    A list of DHCS Priority Z codes with titles can be found in the Appendices section of the Documentation Manuals on the CalMHSA website. Additionally, BHIN 22-013 provides guidance about which ICD-10 codes may be used during the assessment phase of treatment. More detailed information about Z codes can be found in the DSM-5, chapter titled "Other Conditions That May Be a Focus of Clinical Attention" on page 715.

32. **Can non-licensed staff utilize all Z codes or just Z55 to Z65?** *Added 12/30/22*
    Per CalMHSA, the only codes that can use by non-LPHA/LMHP staff are Z55 to Z65, as noted in BHIN 22-013.

33. **What does CANS "*informing*" the assessment mean?**

    The Child and Adolescent Needs and Strengths (CANS) tool can be used to inform the categorial (domain-based) assessment but does not replace it. That means, you can use the information you obtain from the CANS to fill in the different sections of the assessment, as appropriate. Existing timeframes (60 days, 6 months and at discharge) for CANS completion have not changed.

    a. **Is a narrative section for items addressed in the CANS still needed in the assessment document?** A narrative is not required. However, it is recommended as it helps explain the scores, especially ones of significance. This can also be done in the assessment document.

    b. **If a Domain is addressed in the narrative of the CANS, does it have to be rewritten in the Assessment?** No, it can just be referenced in the Assessment note.

34. **Assessment domains 3 and 4 list "*comorbidity*" in regard to behavioral health alone or medical and behavioral health, what does this mean? Is this specific to substance use and MH conditions or does it include Developmental Disabilities, social determinants of health (SDOH), medical conditions?**

    The Assessment domains, including "comorbidity" in Domains 3 and 4 have been clarified in the SMHS Documentation Manual on the CalMHSA website.

35. **The IN does not establish a "reasonable timeframe in accordance with generally accepted standards of practice" for doing an initial MH assessment. Will ACBH defer to the providers and clinicians' judgment on these standards?** *Updated 7/18/22*

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ACBH is following the State's guidance regarding timeliness requirements and not setting timeframes for completion of initial assessments or establishing a formal diagnosis for SMHS providers. While there may not be specific timeframes, Medi-Cal does require that MH assessments be completed within a reasonable amount of time and according to generally accepted standards of care. It is our position that best practices involve completing a thorough assessment and establishing an accurate diagnosis as quickly as possible. Some beneficiaries may require treatment services prior to completion of the assessment and diagnosis, however for most individuals, completion of the assessment process should be prioritized during this initial phase of treatment. When actual practices differ from generally accepted standards, documentation of the reason needs to be explained in the medical record. Additionally, notes should identify steps the provider is taking to gather the needed information in order to complete the assessment (e.g. requesting records, interviewing family, etc.) and the assessment should be promptly completed once the information is received.

For services where care plans are still required, the assessment due date would logically have to be prior to the plan due date as the assessment is used to develop the plan.

36. **If updates are only needed when clinically appropriate for assessment, will ACBH defer to the providers and clinicians' judgment on when this is necessary?** *Updated 7/18/22*

ACBH is following the State's guidance related to SMHS assessment updates and expecting that updates will be completed in line with clinical best practices and reasons for delays are documented in the notes.

37. **If elements of an Assessment or Assessment update are included somewhere else in the record, such as in the Progress notes, will that be acceptable?**

There is no requirement that providers use a specific form to document assessment information; however, pertinent clinical information should be easily locatable and accessible by providers to inform treatment.

Additionally, information needs to be available at the time of audit. When clinical information is spread out across a medical record, it can be difficult to locate.

38. **Assessment Section A, item F, indicates inclusion of a diagnosis. Will ACBH accept any ICD 10 code (including the use of Z codes), since DHCS has clarified that a DSM 5 diagnosis may not ever be required for services?** *Updated 12/30/22*

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Most of the beneficiaries regardless of age in the SMHS system (moderate to severe) will likely meet criteria for a MH diagnosis. Per BHIN 22-013, MHPs, DMC and DMC-ODS programs and providers may use the following options during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established:

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). Codes Z55-Z65 have been added to the SUD and SMHS environments for CG and InSYST.

- 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 LMHP in the CMS approved ICD-10 diagnosis code list1 , which may include Z codes. LPHA and LMHP may use any clinically appropriate ICD-10 code 2 . For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

In the DMC-ODS system, beneficiaries are not required to meet criteria for a SUD diagnosis in order to receive services during the assessment period. After the assessment period however, adults are required to meet criteria for a DSM SUD diagnosis (except tobacco and non-substance addictive disorders). Adolescents may receive both assessment and treatment services throughout a treatment episode when they do not meet criteria for a DSM SUD diagnosis. Adolescents who meet criteria for a SUD diagnosis are not eligible for Early Intervention Services (ASAM 0.5).

Regardless of the delivery system, proper diagnosing is still an essential component of quality clinical care and all beneficiaries must be continually assessed for SUD and MH diagnoses. Additionally, per CMS rules all Medi-Cal claims must have an associated ICD-10 diagnostic code.

39. What are the new requirements for completing the American Society of Addiction Medicine (ASAM) criteria?

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Providers offering DMC-ODS services are required to use the ASAM Criteria to determine placement into the appropriate level of care for all beneficiaries. The ASAM criteria is separate and distinct from determining medical necessity.

A full assessment utilizing the ASAM criteria is not required for a DMC beneficiary to begin receiving covered and reimbursable SUD treatment services; an abbreviated ASAM screening tool may be used for initial screening, referral and access to clinically appropriate services.

40. What are the timeframes for initially completing and repeating the ASAM criteria?

The chart below was shared in the ACBH Memo dated May 16, 2022:

Level of Care	ASAM Requirements at Initial Assessment	ASAM Requirements Ongoing
Level 1 OS (Outpatient Services), OTP (Opioid Treatment Program) Level 2.1 IOS (Intensive Outpatient Services)	Full ASAM[1] within 30 days for adult or within 60 days if under 21 years old or homeless.	When beneficiary's condition changes.
Level 3.1 Residential – Clinically Managed Low-Intensity Residential Services Level 3.3 Residential - Clinically Managed Population – Specific High Intensity Residential Services Level 3.5 Residential - Clinically Managed High Intensity Residential Services	Full ASAM[1] within 5 days ***COUNTY NOTE**: Per UM prior authorization policy, a brief ASAM screening will continue to be completed by Portal prior to admission.*	When beneficiary's condition changes ***COUNTY NOTE**: As authorization for services is required for Residential level of care, ACBH will continue to require that a full ASAM be completed when requesting authorization after the first 5 days- for up to 30 days and whenever additional authorization is requested.*[2]
Level 3.2 - WM Residential - Clinically Managed Withdrawal Management Level 3.7 – WM	A full ASAM is not required to admit to withdrawal management ***COUNTY NOTE**: Complete a brief ASAM (ALOC Portal Screener in CG) within 24 hours of admission.*	May use ASAM or other brief assessment tool to support appropriate transition ***COUNTY NOTE**: Complete all ASAM Dimensions (ALOC Portal*

[1] **Full ASAM**: ACBH is designing a new, streamlined note type that combines ALOC and Intake/Assessment.
[2] ACBH is designing a new note type for requests beyond the first 30 days of residential services.

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Medically Monitored Intensive Withdrawal Management Services	*May complete only the clinically relevant ASAM Dimensions. To allow capturing of ASAM and timelines data, a completed brief ASAM is required even if the client leaves within 24 hours of admission.*	*Screener in CG) for transitions of care prior to discharge.*

41. **What is the difference between a full ASAM assessment and a brief ASAM assessment?**
A full ASAM assessment is one when all six (6) dimensions are required for assessment. For a brief ASAM assessment, only the dimensions needed to make a level of care determination are required. For example, assessing all dimensions is not necessary to know a beneficiary needs residential withdrawal management.

42. **Will there be adjustments to the Notice of Adverse Benefit Determination (NOABD) process if CBOs no longer have to diagnose?**

No, there are no changes to the NOABD process. The flexibilities introduced to the diagnostic formulation process are aimed at allowing access to services even before the establishment of a diagnosis. However, diagnoses remain a standard of sound clinical treatment and are important to providing quality care.

43. **For youth who qualify for SMHS based on their experience of trauma or child welfare involvement or adults who are homeless, will that access criteria be sufficient to establish medical necessity?**

According to BHIN 21-073, access criteria for beneficiaries under 21 years of age includes the following:

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

If a beneficiary under 21 years of age meets the above criteria, the details should be clearly noted in the medical record and will be sufficient to establish medical necessity.

44. **Assessment Domain 7 includes three bullets: *Clinical Summary and Recommendations, Diagnostic Impression, Medical Necessity Determination/Level of Care/Access Criteria*. Are all three required? What if the diagnosis is a Z code?**

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Yes, all are required. For Z codes, specific information to support that Z code is sufficient. Details of Domain 7 are clarified in the Documentation Manual on the CalMHSA website.

45. **The documentation requirements state that "*The Mental Health Plan (MHP) may designate certain other qualified providers to contribute to the assessment, including gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals*." Based on this statement, what roles and assessment activities will ACBH authorize outside of LPHAs?**

    There are no changes to scope of practice requirements as a result of CalAIM. Non-LPHA staff may still gather information for the assessment, but they may not engage in assessment of beneficiary's conditions.

    See the Scope of Practice Matrix in the in the Documentation Manual on the CalMHSA website.

46. **There are some differences between the CalMHSA Scope of Practice Matrix in the and the ACBH Guidelines for Scope of Practice. Where there are difference, which one should be followed?** *Added 12/30/22*

    ACBH has been trying to reconcile the differences, but unable to do so. Where there are differences, providers should follow the ACBH Guidelines for Scope of Practice Credentialing document.

47. **DHCS states that the assessment doesn't need to be co-signed by a licensed clinician. Can we expect ACBH will adopt this standard and allow AMFT/ACSW to complete and sign it on their own?**

    The BHIN 21-073 states that "The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health must be completed by a provider, operating in his/her scope of practice under California State law, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional as defined in the State Plan."

    As noted in BHIN 17-040 and 9 CCR 1810.314, DHCS requires that MSE and diagnosis are provided under the direction of a licensed mental health provider. The County's requirement of a co-signature is to ensure that a licensed LPHA is overseeing these services.

48. **Is there a plan for sharing the Assessment document across all contracted MHP providers?**

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One of the goals of CalAIM, is to build an integrated system where the clients' needs can be managed holistically. This Administrative Behavioral Health Integration is planned for roll out by January 2027.

Until that time, providers are expected to continue to coordinate services as necessary to meet the needs of the client. Care coordination involves communication across multiple disciplines and organization. To ensure smooth coordination of care, practitioners should request authorization to share information (also known as releases of information) for all others involved in the care of the person in treatment during the intake process and throughout the course of treatment.

49. **I don't see any reference to the need for an Adult Needs and Strengths Assessment (ANSA) for 21+ clients. Can we assume that this is not a requirement with CalAIM?**

    No, the County has not removed the requirement for completing the ANSA.

50. **Are the CANS/ANSA and Pediatric Symptom Checklist (PSC-35) still due every 6 months?** *Updated 7/18/22*

    Yes. There are no changes to PSC-35 and CANS/ANSA requirements at this time. The current CANS/ANSA and PSC-35 requirements are in ACBH Policy 1601-1-1 available in the ACBH Policy and Procedures Manual.

51. **What is the interpretation of "*The problem list and progress note requirements identified below shall support the medical necessity of each service provided*"? How will medical necessity be defined if there is a Z code diagnosis?**

    The use of a Z code does not absolve a provider from assessing for medical necessity or access criteria for services. Z codes allow services to be claimed when a beneficiary does not meet criteria for a DSM diagnosis or when the diagnosis cannot be immediately established. All services, regardless of what diagnostic codes are used, still require that medical necessity and access criteria for the specific delivery system be documented in the medical record. One way would be to include in the assessment, a detailed description of beneficiary's current presentation, impairments to functioning, experiences of trauma, homelessness, or other relevant factors.

52. **Can we bill for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), or Therapeutic Foster Care (TFC) during the assessment period, if we provide documentation of eligibility (e.g. a youth that meets one of the criteria for IHBS)? For example, can we get authorization for IHBS before we finalize an assessment?**

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No. According to BHIN 22-019, ICC, IHBS and TFC services for Medi-Cal beneficiaries continue to require a care plan.

53. **For DMC-ODS, must a SUD diagnosis be provided to continue services at the end of the 30-day assessment period for adults?** *Updated 7/18/22*

    Yes, with the exception of adolescent beneficiaries (ages 12 to 20) and adults who are homeless, an assessment must be completed within 30 days of the first visit with a Licensed Practitioner of the Healing Arts (LPHA), or registered/certified counselor. For adolescent beneficiaries or adults who are homeless and need more time to complete the assessment, the timeframe is 60 days.

54. **Should providers continue to use the CG templates titled ALOC and SUD/Intake and Assessment for documentation or is there a plan to create new templates in CG?** *Updated 7/18/22*

    CalAIM has changed initial assessment requirements. The county is currently working to consolidate and simplify our existing templates for the DMC-ODS providers. We will work closely with our BH Collaborative partners and notify the providers prior to publishing any new note templates. Until then please continue to use existing templates.

55. **If residential providers have clients with authorization through 90 days, can they wait until next authorization to renew the ALOC?** *Added 7/18/22*

    ASAM criteria assessments need to be completed whenever additional authorization is being requested or whenever there is a change in the beneficiary's condition.

56. **Are there any changes to the 6 month Justification of Services (JOS) and Justification of Continued Treatment (JCT) requirements for outpatient DMC-ODS?** *Updated 7/18/22*

    Outpatient services still require the 6-month justifications at this time. DHCS is reviewing this requirement, but it is currently still in place for outpatient programs. Continuing service justification is not required for residential services as extensions are authorized by ACBH Utilization Management (UM).

57. **Are there any changes to the requirements for Narcotic Treatment Programs (NTP)?** *Added 7/18/22*

    Opioid Treatment Program (OTP) and NTP medical necessity and documentation requirements, as specified in 9 CCR, Div. 4, Ch. 4 Narcotic Treatment Programs, have not changed.

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Problem List

58. Please confirm that ALL clients require a Problem List, including those that also have a Treatment Plan and/or Peer Support Care Plan.

Correct. Services that require creation of a Care Plan, now also require Problem Lists. The only exception is for OTP/NTP services.

59. Will ACBH defer to the provider or clinicians on the timeframe for the initial problem list creation?

DHCS does not require the problem list to be updated within a specific time frame or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice. Accuracy of the diagnoses and problem list are necessary for appropriate treatment services to a person, and to support claiming for services. Inconsistencies in either can lead to poor coordination of care across teams and treatment as well as inadequate documentation of the medical necessity of services, which can lead to rejected claims.

While ACBH has not designated a due date, it is our perspective that a problem list should be started as early as possible in the treatment episode. A problem list is intended to be dynamically updated as problems are identified, and likely enough information will be available to start a problem list after the first encounter with a beneficiary.

60. If a Problem List or Care Plan includes a change in diagnosis, must a licensed LPHA co-sign and attest to the updated diagnosis?

As noted in BHIN 17-040 and 9 CCR 1810.314, DHCS requires that MSE and diagnosis are provided under the direction of a licensed mental health provider. The County's requirement of a co-signature is to ensure that a licensed LPHA is overseeing these services.

61. What if there are two Problem Lists or Care Plans with separate providers:

- **Can there be different diagnoses?** Between providers, different diagnoses may occur. Ideally care coordination services will be utilized to sync services both inter and intra agency. Within an agency it continues to make sense that services would be aligned. Misalignment of services can negatively impact the overall treatment of a beneficiary and their families and should be avoided.

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- **What about Therapeutic Behavioral Services (TBS), short-term residential therapeutic program (STRTP), and ICC services - must the diagnosis match with those?** While there is no specific requirement that diagnoses be aligned between specialty services, if there are significant differences care coordination services can be used so providers are not working at cross purposes. If there are differences in treatment team provision of services that impede or impair the services a beneficiary is receiving, care coordination services should be utilized to address these issues.

- **What if one provider doesn't use a DSM diagnosis?** For significant differences such as this, it is necessary that providers work together to coordinate care.

- **How can info be shared?** CalAIM changes have not impacted information sharing rules and regulations. As the state and federal government update patient privacy laws ACBH will update our policies as well.

- **Is there a plan for sharing the problem list across all contracted MHP providers? If so, how?** At this point, there have not been discussions on this topic due to significant logistical and technological challenges. ACBH does not currently have any policies that restrict legal sharing of information between providers.

62. The IN specifies that "*The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.*" If the problems or illnesses are identified by the beneficiary and/or significant support person, do we need to include name/date of this addition/removal of information?

Yes, the problem will need to be added to the list. Problem list requirements are clarified in the Documentation Manual on the CalMHSA website.

The problem list shall be updated on an ongoing basis to reflect the current presentation of the person in care. The problem list shall include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice, if any. Include diagnostic specifiers from the DSM if applicable.
- Problems identified by a provider acting within their scope of practice, if any.
- Problems or illnesses identified by the beneficiary and/or significant support person, if any.
- The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.
- Providers shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition.

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63. **Does the Problem List have to include the date the problem was identified or the date it was added to the list?**

    The date the problem was added to the list.

64. **From an audit perspective, where does the problem list need to reside in the medical record? If all elements of the Problem List are included somewhere else in the record or by a different name than Problem List, will that be acceptable?** *Updated 7/18/22*

    One of the goals of CalAIM is to provide a more holistic approach to care through care coordination and system integration. The Problem List is a tool that is currently used in physical healthcare. As this tool is implemented within the behavioral health system, the name should remain the same to support a common understanding across the systems of care. Additionally, the Problem List should be easily identifiable within the provider's Electronic Health Record and be provided to ACBH as requested at the time of an audit.

    ACBH has developed a problem list tool in Clinician's Gateway (CG) that is currently available for use in both the MH and SUD CG environments.

65. **Will Z-codes be available for adding to the problem list?**

    All problems on the list must have a corresponding ICD-10 or Systematized Nomenclature of Medicine (SNOMED) code. These codes can be found on CMS.gov. Yes, the new Problem List template in Clinician Gateway will include a list of available codes and corresponding problem names within a drop-down menu.

66. **Would there be visibility into what other providers are adding to the problem list? Specifically, providers across different agencies? Would there be a "blanket ROI" which allows MH providers to access SUD charts for example?** *Added 7/18/22*

    Not yet. The County is monitoring this but there have been no changes to 42 CFR, Part 2 at this time.

67. **For residential programs, are both a treatment plan and a problem list required?** *Updated 12/30/22*

    Yes.

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SMHS Targeted Case Management (TCM)

68. Does TCM apply to SUD Residential Treatment services and Care Coordination?

No. Care Coordination services in the DMC-ODS system are not considered TCM and therefore do not require a Care Plan.

69. Why haven't MH case management requirements changed like other services due to CalAIM? *Added 12/30/22*

Case management services provided within SMHS are considered targeted case management services and are guided by federal regulations and requirements. As CalAIM is a California initiative, federal requirements were not impacted by the CalAIM changes. TCM requirements are spread out over a few different places, including the following sources:

- State Plan Amendment, Supplement 1 to Attachment 3.1-A (pages 8 to 16).
- 42 CFR §§ 440.169 and 441.18

Due to the complexity of SMHS TCM requirements, we recommend all programs that bill Case Management/Brokerage services review the above linked requirements to ensure compliance.

70. What are the assessment requirements for beneficiaries who are receiving SMHS targeted case management services? *Added 12/30/22*

SMHS TCM assessment requirements are described in a few different places, including:

- State Plan Amendment, Supplement 1 to Attachment 3.1-A, (D)(1)).
- 42 CFR § 440.169 (d)(1)

TCM assessment requirements may be integrated within the SMHS domain-based assessment or as a separate assessment. TCM assessments are conducted on an annual basis or at a shorter interval as appropriate. When billing for assessment activities related to assessing for case management needs, use the case management procedure code.

71. What are the care plan requirements for beneficiaries who are receiving targeted case management services? *Added 12/30/22*

SMHS TCM care plan requirements are described in a few different places, including:

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- State Plan Amendment, Supplement 1 to Attachment 3.1-A (Sections (D)(2) and (D)(4)(b)).
- 42 CFR §§ 440.169 (d)(2) and 441.18 (8

The TCM care plan is based on case management needs identified during the assessment. Per BHIN 22-019 (page 8), the required elements of the care plan "shall be provided in a narrative format in the beneficiary's progress notes." A TCM care plan is not required after every TCM service, however must be completed when case management needs are identified. Monitoring and update of the Client Plan is conducted on an annual basis or at a shorter interval as appropriate. Collaboration with the beneficiary is required to develop the care plan, but they do not need to sign the plan/progress note. When billing for care plan activities solely related to case management, use the case management procedure code. If developing a MH treatment plan (e.g. for STRTPs) that includes case management, use the MH Plan Development code.

72. Can we use other Healthcare Common Procedure Coding System (HCPCS) codes to capture brokerage, therefore not needing a Care Plan for Targeted Case Management (TCM)? *Updated 7/18/22*

No. Services must always be claimed using the appropriate code. Related, due TCM codes often reimbursing at different rates, we do not recommend combining case management services with billing for other services as this may result in overbilling which is not allowed.

73. When TCM is offered as a one-time referral or support, does it still require the creation of a Care Plan?

Yes. BHIN 22-019 does not make an exception for this scenario. It specifies that TCM, which is the same thing as Case Management, requires a Care Plan that is based on the information collected through the assessment. Clinically appropriate and covered services, including TCM, can be provided prior to the TCM Care Plan being developed, during the assessment process. A care plan should be developed after an assessment.

Care Plan

74. What are CalAIM DMC-ODS treatment (or client) plan requirements? *Updated 12/30/22*

With the CalAIM changes, treatment or client plans are no longer required for DMC-ODS services starting 7/1/2022, with some exceptions. Treatment plans continue to be required if

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SABG funds are used for a beneficiary's treatment as specified in the Minimum Quality Drug Treatment Standards for SABG.

If SABG funds are used to fund program-wide activities such as administrative costs, salaries, etc., all beneficiaries at that program are required to follow SABG requirements. If SABG funds are used to provide services to specific beneficiaries only, SABG requirements only apply to those specific beneficiaries. As all residential programs receive SABG funds for board and care services for each beneficiary, all beneficiaries at ACBH contracted SUD residential programs require treatment plans per SABG.

See ACBH memo for more information.

75. What does a Care Plan look like now with the implementation of dynamic Problem Lists? What are the minimal requirements (Discharge planning, Goals, Strengths, Measurable objectives, Interventions)?

The requirements of a care plan depend on the regulations that require the plan.

DHCS is requiring that TCM and Peer Support care plans be documented in a narrative format within a Progress Note. The Documentation Manual on the CalMHSA website lists the required elements of a TCM care plan as follows:

- Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the beneficiary;
- Includes activities such as ensuring the active participation of the beneficiary, and working with the beneficiary (or the beneficiary's authorized health care decision maker) and others to develop those goals;
- Identifies a course of action to respond to the assessed needs of the beneficiary; and
- Includes development of a transition plan when a beneficiary has achieved the goals of the care plan.

76. Does the transition plan have to be included in the Care Plan when the Care Plan is initially developed or is it ok if it is added later on once the goals are met? *Added 12/30/22*

The language provided by the State can be interpreted in different ways. As with discharged planning, it is useful to think ahead about the potential needs of the client so that appropriate resources can be identified. With that in mind, transition planning following achievement of

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goals can be discussed with the client and started proactively. Providers are asked to do what makes clinical sense depending on the individual needs of the case.

ACBH is checking with the State regarding their expectation related to transition planning and will update this FAQ once an answer is received.

77. **What signatures are required (clinician, client) on the Care Plan?**

    It depends on the requirements of the service or location. Refer to BHIN 22-019, Attachment 1 for more details.

78. **Does a Care Plan revert to the old requirements? Is Treatment Plan different? Is a Plan of Care different?** *Updated 12/30/22*

    The terms care plan, client plan, treatment plan, etc. are generally interchangeable. However, the specific requirements for a plan are dependent on the regulations, licensing standards, etc. that require that plan. SMHS and DMC-ODS no longer require plans but other federal and state requirements remain in place. See BHIN 22-019, Attachment 1, for details of which services require a plan and the governing authority for each. Additionally, as noted above, SABG funded programs continue to require care plans.

79. **In BHIN 22-019 DHCS requires that Case Management Care Plans are included in a Progress Note. Is this also true for levels of care that require Care Plans for all their services (e.g. Residential, Narcotic Treatment Programs, etc.)?**

    The BHIN specifies that required elements of a TCM and Peer Support Services Care Plan must be documented in the beneficiary's progress notes. However, it does not change treatment / care plan requirements for those services outlined in Attachment 1.

80. **Does BHIN 21-073 change the clinical documentation timeline for STRTPs given that care plans are due within 10 days and are usually developed around diagnoses?**

    Per BHIN 21-073: "A treatment plan is required for services provided in STRTPs." The documentation timelines for STRTPs will not change based on medical necessity/access criteria changes. Given the intensity of needs and clinical presentation typical of an STRTP client to require this high level of care, most, if not all, beneficiaries will meet criteria for a mental health diagnosis. However, in the rare case that a mental health diagnosis cannot be established, care plans are developed around a client's symptoms and functional impairments, which is often categorized into diagnostic criteria.

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81. What procedure code or codes can I use to claim for services related to plans? *Added 12/30/22*

For SMHS providers:

If the plan development service provided is related to the development, updating, or reviewing of mental health plans (e.g. peer services, STRTPs, residential etc.), then it is acceptable to use the Plan Development code (InSyst 581, HCPC H0032). If the service is solely for the purpose of developing, updating, or reviewing case management plans (e.g. TCC and ICC) then the case management code (HCPC T1017) must be used. If a mental health plan (e.g. with MH goals, objectives, interventions, etc.) is being developed that includes case management services then code Plan Development (581) may be used. This is because: 1) case management, while a service provided within the SMHS delivery system, is not technically a mental health service, 2) the definition of TCM from 42 CFR § 440.169 (d)(2) (note ICC is a type of TCM) includes all aspects of the case management service (assessment, plan development, referring, linking, monitoring), and 3) TCM typically reimburses at a lower rate from MH services and cannot be combined with higher cost services (overbilling). In general, any services related to the provision of TCM should be claimed using the TCM codes (HCPC T1017).

For DMC-ODS providers:

DHCS has phased out all plan requirements for SUD programs, except those required for SABG funded programs. SABG plan requirements can be found in the Minimum Quality Drug Treatment Standards for SABG, Document 2f(b), section (B)(2)(b). Outpatient SUD providers may use the Individual Counseling or Assessment codes for services related to treatment plans. For SUD residential programs, this activity is included in the day rate and should documented in the daily note.

Progress Notes

82. Progress notes have recently each needed to justify medical necessity, which is no longer listed in the BHIN in the section related to progress notes which states the assessment will need to show this. Please confirm this is no longer a requirement for individual progress notes.

Correct, it is no longer required that every progress note justifies medical necessity for all services. However, progress notes must include sufficient detail to support the service codes selected for the service type. The actual length and detail of the note must meet this standard. The required elements of a Progress Note are described in the Documentation Manual on the CalMHSA website.

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83. How will the "narrative" requirement of the progress note be defined? Can the narrative be simply a reference to addressing the Problem List or Care Plan or will there be county-specific length or content requirements?

Progress notes must include sufficient detail to support the service codes selected for the service type. The actual length and detail of the note must meet this standard. See the Documentation Manual on the CalMHSA website for examples of Progress Notes.

84. Will a checklist of interventions be acceptable as part of the narrative? Similarly, if interventions are repeated verbatim across multiple notes will that be interpreted as fraud even if those are accurate to the service being provided?

CMS documentation rules (e.g. copy/paste, cloning, individualization, etc.) of progress notes are still in place. See page 2 of the CMS guide for details related to Cloning.

85. Can we drop all Behavior, Intervention, Response, and Plans (BIRPs) and Problem, Intervention, Response, and Plans (PIRPs) and Subjective, Objective, Assessment, and Plans (SOAPs) and just include problems and interventions and plan? We currently train clinicians to write in the BIRP format. May we simply adjust that to PIRP, referencing a Problem instead of a Behavior?

The new regulations do not require the use of SOAP, BIRP or PIRP formats.

86. Can you confirm that the following level of detail would be sufficient for a progress note narrative for a claim for CPT Code 90837 (psychotherapy, 60 minutes):

"This writer provided individual therapy to address the client's symptoms of depression and thoughts of self-harm. Plan: Client will continue to utilize coping skills and will attend a socialization group at the wellness center. Next scheduled therapy appointment is May 3 at 4 PM."

According to BHIN 22-019, two narrative sections are required:

1. A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).
2. Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

The example provided does not meet these two requirements.

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Please refer to the Documentation Manual on the CalMHSA website for examples of Progress Notes.

87. **Does a full description of the problem have to be attached to the note or can we reference the number assigned to a problem in the list?**

    There is no requirement that specific problems be referenced in a progress note. However, referencing problems with numbers may be problematic if the numbers change and is not recommended.

88. **What does location of the beneficiary mean for telehealth? Is "telehealth" sufficient as a location?**

    Telehealth is a Place of Service (POS) code. Note that DHCS may be adding additional telehealth POS codes to further distinguish the different types of telehealth locations.

89. **If one provider can document and sign a progress note documenting for two providers for a group session, what about other situations where two staff provide a service (such as a family therapy session)? Can one write and sign the note, with no signature from the second provider?**

    That is not clarified in the BHIN and will need to be researched.

90. **For DMC-ODS, what does the requirement of a daily progress note for services entail?**

    - **Who is responsible for entering that daily note?** No changes from current process. For SUD residential programs it must be a staff member who provided a service to the beneficiary on the day of claiming.

    - **Can an admin staff complete the note and a LPHA sign off on it?** We currently have a process for data entry. That process is not changing. Admin staff can complete data entry activities related to daily services and can enter in narrative content when written by a SUD Counselor or LPHA. However, they cannot write the narrative themselves and the note needs to be signed by a clinical staff.

91. **Can a progress note be started, with late entry after 3 days of additional narrative content or will this be prohibited?**

    Progress notes are required to be completed within 3 business days from the date of service. Starting a note then completing it later does not change this requirement.

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The following are timeliness requirements for Progress Notes as noted in the Documentation Manual on the CalMHSA website :

- Routine outpatient services: Documentation should be completed within three business days. If a note is submitted outside of the three business days, it is good practice to document the reason the note is delayed. Late notes should not be withheld from the claiming process. Based on the program/facility type (e.g., STRTP DHCS regulations), stricter note completion timelines may be required by state regulation.
- Crisis services: Documentation should be completed within 24 hours.
- A daily note is required for documentation of some residential services, day treatment, and other similar settings that use a daily rate for billing. In these programs, weekly summaries are no longer required.

92. For daily services such as Residential treatment billing, when does the 3 days start?

ACBH is interpreting the 3-business day rule as liberally as possible and the day of service is day 0. If a service was provided on a Tuesday, then the note is due by end of the day on Friday. If a service was provided on a Friday, then the note is due by Wednesday of the next week.

93. Are there *any* exceptions for late notes completed after 3 days or will that service become unbillable?

DHCS has indicated individual exceptions are understandable, but this would be an occasional occurrence. The county and/or agency should have monitoring processes in place to monitor for widespread issues with note timeliness, but an occasional issue with not meeting this requirement is acceptable.

Disallowances in audits will only occur when there is evidence of fraud, waste, and abuse. Documenting accurately, in a timely manner and in alignment with the guidelines are necessary steps to promote compliance.

94. The requirements say documentation "should" be completed in 3 days but doesn't say "must" be. *Added 7/18/22*

DHCS uses the words "must" and "should" interchangeably. By "should", they mean "must."

95. With all of the CalAIM changes there is some confusion regarding whether or not travel time can be claimed. *Updated 12/30/22*

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Yes. Travel time is still claimable. Transportation services however are not a claimable service. Travel time is when a clinician travels to meet a beneficiary in the community. For example, traveling from the office to a beneficiary's home and then back to the office. A beneficiary is not present for time that is considered travel time. Transportation is different and is when a beneficiary is transported from one place to another. For more details see DHCS Transportation requirements.

In July 2023 DHCS is expected to complete CalAIM payment reform. "As part of payment reform, specialty mental health and SUD services will transition from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, known as Current Procedural Terminology (CPT) coding, when possible." At that time, we are expecting that travel time and documentation time will be accounted for differently than under current claiming rules.

96. **In non-group situations where two clinical staff provide a service to a single beneficiary at the same time (e.g. family therapy), could the service be documented using one progress note as described in the group services section of BHIN 22-019, or do those rules only apply specifically to group services?** *Added 12/30/22*

    Section 4(E) of BHIN 22-019 states it applies to group services – the BHIN does not state it applies to scenarios as described above, so we would not recommend applying 4(E) requirements to non-group services.

97. **Will counties still need to track travel time and documentation time post rollout of CalAIM payment reform. It would be really helpful to know, as we are working right now on configuring our EHR.** *Added 12/30/22*

    Yes that is correct. Progress note requirements for SMHS are described in BHIN 22-019 and we have been told will persist past implementation of CPT code changes. It will still be very important to track travel and documentation time, even though it won't be reimbursed separately, to allow for data analysis to ensure that reimbursement rates are calculated properly.

    Related to time requirements on progress notes, BHIN 22-019 indicates these are the required components: Duration of the service, including travel and documentation time.

Service Modalities

98. **What is the difference between *Physician Consultation* and *Clinician Consultation*?**

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Physician Consultation service has been updated and is now called Clinician Consultation. Clinician Consultation is exactly the same as Physician Consultation except for one key area: Any licensed LPHA may contact the ACBH-designated addiction specialist to consult on challenging cases. Previously only a physician could use this service. ACBH is working to update the procedure codes to reflect these changes. This is unique to the DMC-ODS system. For more information see BHIN 21-075.

99. Is Dr. Kayman approved as an ACBH designated consultant for Clinician Consultation services? *Added 7/18/22*

Yes.

100. When our staff interact with Dr. Kayman, can that be entered as clinician consultation on our end? *Updated 7/18/22*

Clinician Consultation is when a licensed LPHA consults with the ACBH consultant. So yes, if your staff is a licensed LPHA.

101. Can DMC-ODS providers still claim Collateral Services?

No. With the CalAIM changes, collateral services are no longer a DMC-ODS covered service type. The reason for this is that collateral services are specifically in support of achieving care plan goals and objectives. Since care plans (treatment, client, etc.) are no longer required in DMC-ODS services, Collateral Services are no longer necessary. Alternative service types to collateral may be care coordination, counseling, or assessment services.

102. Did Alameda County opt to have Peer Support Services as a distinct service type? *Updated 7/18/22*

Yes. Multiple ACBH units are working diligently to develop this modality.

103. How is "Peer Support Services" defined?

Peer Support Services is a new and specific service type defined for both SMHS and DMC-ODS in several Information Notices. BHIN 22-026 defines Peer Support Services as culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse,

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empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery.

Peer Support Services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer Support Services can include contact with family members or other collaterals (family members or other people supporting the beneficiary), if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's goals. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

104. If an agency has similar roles to a Peer Support Specialist (PSS) but by a different name (e.g. Parent Partner) can they bill Rehab or other SMHS without a Care Plan?

PSS are rapidly evolving and have to meet specific standards. According to BHIN 22-026, Peer Support Services include the following service components:

- Educational Skill Building Groups
- Engagement
- Therapeutic Activity

Please see BHIN 22-026, 22-018, 22-006, 21-045, and 21-041 for more details.

105. Can PSS only bill Peer Support Services if they are certified? Do all peer staff need to be certified?

BHIN 22-026 states the following:

A PSS is an individual with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and who meets all other applicable California state requirements, including ongoing education requirements.

Certified Peer Support Specialists (CPSS) provide services under the direction of a Behavioral Health Professional. A Behavioral Health Professional must be licensed, waivered, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of DMC, DMC-ODS, or SMHS. Although Peer Support Services must be provided under the direction of a Behavioral Health Professional, CPSS may be supervised by a PSS Supervisor who must meet applicable

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California state requirements. For additional guidance regarding PSS Certification information and PSS Supervisor standards, see BHIN 21-041.

CPSS can only use specific HCPCS as provided by DHCS and CMS. BHIN 22-026 has more information and ACBH has to implement these codes in each delivery system.

106. Are all PSS automatically included into this newly defined Medi-Cal Provider type, or could they continue operating under the same guidelines as other adjunct staff? *Added 7/18/22*

PSS must be certified by CalMHSA if they want to bill under the new codes, Procedure Code H0025 & modifier HE (BH prevention and Education services) and Procedure Code H0038 & modifier HE (Self-Help/Peer Support). They can continue as adjunct staff but it would be best if they pursue certification so they can bill for these additional codes that are more aligned with the field.

107. Must a Family Partner be credentialed/certified as a PSS? If so, what are the steps involved? *Updated 7/18/22*

Yes, if they will be using the new codes specific to Parent/Family PSS. Since PSS is a specific provider type, these new codes will only be able to be used by the certified peer, be them a parent, family member or peer. These positions will also require a CPSS Supervisor. DHCS is strongly encouraging that a peer or family member be hired for this supervisory position. There is also a training required for the supervisor. The ideal would be a peer with peer support experience supervising a peer, and a family member with family support experience supervising a family member.

The process of grandparenting is the same for everyone and is noted on the Checklist for Peers document. If someone is looking to be a new Family PSS, they will need to prepare, through various trainings totaling 80 hours for the generalist exam. After they have passed that exam they will receive their certification. In order to get a Specialty designation of Certified Parent/Family PSS, they will have to take an additional 40 hours of training in the specialty core competencies. They only have to show proof of these 40 hours of training. They will not be required to take another exam in order to get the Specialty designation.

Tanya McCullom, Office of Family Empowerment Program Specialist (Tanya.mccullom@acgov.org) and Khatera Tamplen, Office of Peer Support Services Manager (Khatera.Aslami@acgov.org) are leads for ACBH and taking full names and birth dates of PSS and Parent Partners/Family PSS who want a scholarship to get "Grandparented-In" and take

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the exam. Other than this process (which is from now until July 31st) the Peer and Parent Partner staff can apply for a scholarship to go through the initial 80 hour training and take the exam. Tanya and Khatera should also be contacted by those organizations that are considering adding this service to their contract.

108. If a group service is rendered at programs that claim on a daily basis (e.g. residential, DR/DTI), are participant lists required for all groups the beneficiary attends? *Added 12/30/22*

Per BHIN 22-019, "When a group service is rendered, a list of participants is required to be documented and maintained by the plan or provider" (pp. 7). The participant list is specific to the group service provided. So, if a program provides three group services in a day, there would need to be a participant list for each of those groups. The BHIN does not differentiate this requirement based on how services are claimed.

Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Behavioral Services (TBS)

109. How often must SMHS providers re-assess for ICC and how/where should it be documented? *Added 12/30/22*

ICC/IHBS/TFC screenings should be documented in the initial assessment form and updated as clinically appropriate, such as when there is a significant change in the client's condition/presentation (for example, a change in the client's placement, new or increased level of risk, hospitalization, etc.). The updated screening should be documented in the client's record, preferably in an assessment addendum. If the provider does not have the capability of creating an assessment addendum, documentation of the screening in a progress note is acceptable.

110. Do specialty service (ICC, TBS) providers need to create problem lists for clients? *Added 12/30/22*

Yes. With implementation of the CalAIM initiative, all SMHS providers are required to create and maintain a problem list for each beneficiary, regardless of whether or not a treatment plan is required. A problem list may be shared among programs within a single agency.

111. Should progress notes for TBS continue to use the BIRP structure per the TBS Documentation Manual, even though Cal-Aim only requires I and P? *Added 12/30/22*

Yes. Pending further guidance from the state, ACBH is deferring to the TBS manuals for guidance on progress note documentation.

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Timely Access Data Collection

112. With CalAIM changes to assessment timeliness and treatment plan requirements, what date should we use for Assessment Appointment in the CSI form? *Added 12/30/22*

Now that treatment can start without a completed assessment and treatment plan, the Assessment Appointment field in the CSI form should be used to document the date of initial Intake/Screening with the client.

See ACBH memo for more details regarding the CSI form.

113. What are the requirements for timely access data collection for SUD programs? *Added 12/30/22*

On an annual basis, DHCS issues new requirements and guidance related to Network Certification, inclusive of timely access data. With BHIN 22-033, the State issued expanded timely access data reporting requirements for Drug Medi-Cal-Organized Delivery System (DMC-ODS) Plans. These requirements are in-line with those of the Mental Health Plan (MHP) for Specialty Mental Health Services (SMHS). See ACBH memo for more details and SUD Timely Access Data Collection Training on the Provider website.

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