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 Office

Last Updated on June 4, 2022

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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?**

   See calendar of policy changes and go-live dates below:

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?**

   A number of resources have been offered to providers. Most are in the Quality Assurance section of the Provider Website under Memos. Additionally, you can find new policies on the Policy and Procedure page of the Provider Website. Two policies that have been published at the time of this update are the following: 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

   Below are additional helpful resources that are available on the CalMHSA's CalAIM webpage:
   - **Documentation manual**: Documentation Manual for Outpatient Specialty Mental Health Services
   - **Training videos**: At the time of this update, the CalAIM Overview Training is available on the CalAIM webpage. 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.

   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.

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3. **When will Clinician Gateway (CG) be updated to reflect the IN?**

   ACBH is working to update CG as quickly as possible. At this time there is no specific date for completion of needed updates.

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

   Yes. The 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."

5. **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?**

   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.

6. **How does ACBH anticipate introducing International Statistical 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.

   Effective 6/1/22, codes Z55-Z65 have been added to the SUD environment for CG and InSYST. Due to CSI algorithms, adding Z codes to systems for SMHS is more complex and will take longer to complete. Providers will be notified once the SMHS systems are updated. Until that time, SMHS providers should continue to use Z03.89.

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Due to the unique needs of DMC-ODS, effective 6/1/22, codes Z55-Z65 have been added to the SUD environment for CG and InSYST. Adding Z codes to systems for SMHS is more complex and will take longer to complete, due to CSI algorithms. Providers will be notified once the SMHS systems are updated.

7. **How will the Clinical Quality Review Team (CQRT) checklist be revised? Any process changes?**

   Yes, once the requirements are pushed out, CQRT checklists for both Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) will be revised.

8. **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.

9. **Does the BHIN and ACBH's memos supersede any contracts that are contrary to those directions?**

   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

10. **Considering new standards for fraud waste and abuse, is there a window of audit grace?**

    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. ACBH will be following that guidance for audits. DHCS is planning on releasing Reasons for Recoupment for FY 22-23 in October 2022.

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11. **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 not excluded for 1) Services 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 service was not included in an individual treatment plan; 3) The beneficiary has a co-occurring substance use disorder.

12. **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?**

    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. The only disallowances will be based on fraud, waste or abuse.

No Wrong Door

13. **Are we at risk of having the service disallowed if we mention SUD treatment in our 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.

14. **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?**

    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).

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

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Providers are not being required to work out of their scope and abilities. There is now greater flexibility to support an individual with both conditions

16. **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.

Access Criteria and Medical Necessity

17. **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. The BHIN updates the concept of medical necessity as it relates to eligibility for access to Medi-Cal services and refers to access criteria for the distinct behavioral health delivery systems. See BHIN 21-073 for more information

18. **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.

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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 SMHCS and BHIN 21-075 for DMC-ODS.

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 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.

19. **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 Mental Health Plan (MHP) or if they should be referred to the Managed Care Plan (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.

20. **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."

21. **What if someone presents with a Substance Use Disorder (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;
    - 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

22. **Can a substance use disorder (SUD) be billed as a primary diagnosis if there is a mental health (MH) secondary diagnosis?**

    While the language regarding primary and secondary diagnoses has changed, the concept remains unchanged in that SMHS providers cannot treat a stand-alone SUD. However, having a co-occurring SUD does not preclude treatment. SMHS providers have some flexibility in addressing a SUD when it's part of a mental health disorder and reduction in use of substances will improve/ameliorate the mental health symptoms and impairments being treated by the SMHS provider. The connection between the use of substances and the mental health symptoms and impairments should be clearly documented in the medical record.

    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

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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).

Assessment

23. 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.

24. 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, SDOH (social determinants of health), medical conditions?

Comorbidity in Domains 3 and 4 is clarified in the new Documentation Manual, as follows:

Domain 3 focuses on history of behavioral health needs and the interventions that have been received to address those needs. Domain 3 also includes a review of substance use/ abuse to identify co-occurring conditions and/or the impact of substance use/abuse on the presenting problem.

- Mental Health History – Review of acute or chronic conditions not earlier described. Mental health conditions previously diagnosed or suspected should be included.
- Substance Use/Abuse – Review of past/present use of substances, including type, method, and frequency of use. Substance use conditions previously diagnosed or suspected should be included.
- Previous Services – Review of previous treatment received for mental health and/or substance abuse concerns, including providers, therapeutic modality (e.g., medications,

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therapy, rehabilitation, hospitalizations, crisis services, substance abuse groups, detox programs, Medication for Addiction Treatment[MAT]), length of treatment, and efficacy/ response to interventions

Domain 4 integrates medical and medication items into the psychosocial assessment. The intersection of behavioral health needs, physical health conditions, developmental history, and medication usage provides important context for understanding the needs of the people we serve.

- Physical Health Conditions – Relevant current or past medical conditions, including the treatment history of those conditions. Information on help seeking for physical health treatment should be included. Information on allergies, including those to medications, should be clearly and prominently noted.
- Medications – Current and past medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits of medications. When available, the start and end dates or approximate time frames for medication should be included.
- Developmental History – Prenatal and perinatal events and relevant or significant developmental history, if known and available (primarily for individuals 21 years old or younger)

25. The Information Notice does not establish a "reasonable timeframe in accordance with generally accepted standards of practice" for doing an initial assessment. Will ACBH defer to the providers and clinicians' judgment on these standards?

This is currently being discussed. Once a decision is made, it will be shared with providers. 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.

26. If updates are only needed when clinically appropriate for assessment, will ACBH defer to the providers and clinicians' judgment on when this is necessary?

This is currently being discussed. Once a decision is made, it will be shared with providers.

27. Must an updated assessment be completed in the "Assessment section" or is a progress note sufficient?

For SMHS a specific form is not required by DHCS, but due to complexity of the assessment we highly recommend a form be used so required elements are not missed.

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28. **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?**

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). **NOTE:** *Effective 6/1/22, codes Z55-Z65 have been added to the SUD environment for CG and InSYST. Due to CSI algorithms, adding Z codes to systems for SMHS is more complex and will take longer to complete. Providers will be notified once the SMHS systems are updated. Until that time, SMHS providers should continue to use Z03.89.*

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

- In cases where services are provided due to a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMPH in the CMS approved ICD-10 diagnosis code 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.

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Additionally, per CMS rules all Medi-Cal claims must have an associated ICD-10 diagnostic code.

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

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.

30. 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]

[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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Level 3.2 - WM Residential - Clinically Managed Withdrawal Management Level 3.7 – WM Medically Monitored Intensive Withdrawal Management Services	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 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.*	May use ASAM or other brief assessment tool to support appropriate transition ***COUNTY NOTE**: Complete all ASAM Dimensions (ALOC Portal Screener in CG) for transitions of care prior to discharge.*

31. **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.

32. **Will there be adjustments to the 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.

33. **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.

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34. **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?**

    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 as follows:

    Domain 7 provides clinicians an opportunity to clearly articulate a working theory about how the person in care's presenting challenges are informed by the other areas explored in the assessment and how treatment should proceed based on this hypothesis.

    - Clinical Impression – summary of clinical symptoms supporting diagnosis, functional impairments (clearly connected to symptoms/presenting problem), history, mental status exam, cultural factors, strengths/protective factors, risks, and any hypothesis regarding predisposing, precipitating and/or perpetuating factors to inform the problem list (to be explained further below)

    - Diagnostic Impression – clinical impression, including any current medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional or unspecified)

    - Treatment Recommendations – recommendations for detailed and specific interventions and service types based on clinical impression and, overall goals for care.

35. **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.

36. **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 Licensed Practitioner of the Healing Arts (LPHA)s?**

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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 Documentation manual.

37. **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?**

    There is no change to scope of practice requirements as a result of CalAIM. The BHIN 21-073 states this:

    > 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.

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

    ACBH has not discussed this in significant depth, but any sharing of documents that is legally allowable and benefits the beneficiary is open to discussion. ACBH will have to determine logistically how this would work and be effective.

39. **I don't see any reference to the need for an 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.

40. **Are the CANS/ANSA and PSC35 still due every 6 months?**

    Yes. There are no changes to PSC-35 and CANS/ANSA requirements at this time.

41. **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

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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.

42. **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?**

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

Problem List

43. **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.

44. **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.

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

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Scope of practice for who can establish a MH or SUD diagnosis has not changed. The Documentation manual includes a helpful Scope of Practice Matrix.

46. **What if there are two Problem Lists or Care plans with separate providers:**

- **Can there be different diagnosis?** 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.

- **What about TBS, STRTP, and ICC services - must the diagnosis match with those?** While there is no specific requirement that diagnoses be aligned between adjunct MH 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.

47. **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 as follows:

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:

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- 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.

48. **Which of these is required on the Problem List, the date problem was identified or the date the problem was added to the list?**

    The date the problem was added to the list.

49. **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?**

    As long as the requirements of a problem list are met and evidence of that can be provided upon request, there is no specific requirement where in the medical record this document lives, how it is implemented, or what it is called. If an agency prefers to call the problem list by a different name for internal purposes, that is not a concern. It should be noted though that unlike plans, problem lists do not require the beneficiary to review and sign them and likely most beneficiaries will not engage with the problem list on a regular basis.

    ACBH is in the process of developing a Problem List template in CG and will notify providers once the note is available.

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

    All problems on the list must have a corresponding ICD-10 or SNOMED code. These codes can be found on CMS.gov. ACBH is working to build the Problem List in CG so that it includes a list of available codes and corresponding problem names within a drop down menu.

Care plan

51. **CalMHSA seemed to confirm that brokerage/case management (571) requires a Care plan? Since that implies that nearly all SMHS clients will need a Care plan, can we combine the Care plan and Problem List or must there be two separate documents?**

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BHIN 22-019 states that "the required elements of Targeted Case Management shall be provided in a narrative format in the beneficiary's progress notes".

See the Documentation Manual for an example of a Care plan within a Progress Note.

52. **Can we use other HCPCS codes to capture brokerage, therefore not needing a Care plan for Targeted Case Management (TCM)?**

    No. Services must always be claimed using the appropriate code.

53. **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.

54. **What are CalAIM DMC-ODS treatment (or client) plan requirements?**

    With the CalAIM changes, treatment or client plans are no longer required for DMC-ODS services starting 7/1/2022. Per DHCS, counties may not require care plans when not required by state or federal regulations.

55. **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.

56. **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.

    The Documentation Manual states that Targeted case management services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment. The TCM care plan:

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- 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.

57. 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.

58. Does a Care Plan revert to the old requirements? Is Treatment Plan different? Is a Plan of Care different?

The requirements for a care 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.

59. 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.

60. Does BHIN 21-073 change the clinical documentation timeline for Short-Term Residential Therapeutic Programs (STRTP)s 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

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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.

Progress Notes

61. **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.**

    Below are the required elements of a Progress Note as described in the Documentation Manual:

    - The type of service rendered
    - 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)
    - The date that the service was provided to the beneficiary
    - Duration of the service, including travel and documentation time
    - Location of the beneficiary at the time of receiving the service
    - A typed or legibly printed name, signature of the service provider and date of signature
    - ICD 10 code
    - Current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code
    - 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

62. **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 for examples of Progress Notes.

63. **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?**

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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.

64. **Can we drop all BIRPs and PIRPS and SOAPS and just include problems and interventions and plan? We currently train clinicians to write in the BIRP (Behavior, Intervention, Response, Plan) 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, SOAIRP, BIRP or PIRP formats.

65. **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.

The Documentation Manual provides examples of Progress Notes. Below is an example of an Individual Rehabilitation Progress Note:

"In effort to monitor client's moods and emotions, I engaged her in an open-ended conversation about her day and how she has been feeling. I praised her for her reported positive day. I validated her responses and responded with empathy, encouraging her to express her feelings. I discussed and reviewed her current coping skills (i.e., reading, listening to music, etc.). I normalized her need to take a break from difficult situations and reminded her to take time outside. Assisted client in practicing how to let others know that she needs to use her safety plan by engaging in a role play. Client was verbal and engaged throughout the session. I will meet with client next week for an individual rehabilitation session to support her with developing and utilizing coping skills."

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66. **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. Referencing problems with numbers may be problematic if the numbers change and is not recommended.

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

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

68. **How does location of beneficiary intersect with RU/program location? For example, at a school site for school-based services, would client location be "school" or "office" (as the site is an official work site, with a site certification for that provider)? Is it just where the beneficiary is?**

    ACBH is seeking further clarification on this requirement, however we are still likely required to use CMS POS codes.

69. **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.

70. **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.

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

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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.

The following are timeliness requirements for Progress Notes from the Documentation Manual:

- 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.

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

We are currently 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.

73. 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.

74. With all of the CalAIM changes there is some confusion whether or not travel time can be claimed.

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

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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.

Service Modalities

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

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.

76. 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.

77. The BHIN makes the following statement about Peer Support Specialists: "*Peer support services must be based on an approved plan of care. The plan of care shall be documented within the progress notes in the beneficiary's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.*" How is "*Peer support services*" defined?

Peer 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, 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.

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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.

78. **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.

79. **Can Peer Support only bill "peer support services" if they are certified? Do all peer staff need to be certified?**

BHIN 22-026 states the following:

A Peer Support Specialist 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.

Peer Support Specialists 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, Peer Support Specialists may be supervised by a Peer Support Specialist Supervisor who must meet applicable California state requirements. For additional guidance regarding Peer Support Specialist Certification information and Peer Support Specialist Supervisor standards, see BHIN 21-041.

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Peer support specialists 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.