alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

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Specialty Mental Health Services

Frequently Asked Questions (FAQ) Related to Cal-AIM Changes

ACBH Quality Assurance Department

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Access Criteria

For youth who do not have a diagnosis, can providers use any Z code (including those reflecting Social Determinants of Health)?

No. Per Welfare and Institutions Code section 14184.402(f)(1)(A), a mental health diagnosis is not a prerequisite for access to covered SMHS. This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10 diagnosis code. In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to trauma for beneficiaries under 21 years of age, DHCS recommends using options available in the CMS approved ICD-10 diagnosis code list, including "Other specified", "Unspecified" disorders," or "Factors influencing health status and contact with health services". (i.e., Z codes). DHCS may provide additional clarification and technical assistance regarding the use of Z codes. The State has also previously approved the use of Z03.89 "Encounter for observation for other suspected diseases and conditions ruled out". Examples for use of Z03.89 may include: when providing crisis intervention, crisis stabilization, or during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.

Is there a time limit to how long a provider can use a Z code?

BHIN 21-073 does not indicate a time limit on the use of the Z code. However, the intent of this guidance is to remove barriers to care by not requiring a mental health diagnosis as a "prerequisite for access to covered SMHS." The guidance is not removing the requirement to provide a thorough assessment and a diagnosis when treating a beneficiary, as these are critical components of treatment that inform the services that are provided. If a Z code is being used, the documentation should clearly indicate the steps the provider is taking to determine the diagnosis.

The portion of BHIN 20-043 that limits SMHS to a list of DHCS included ICD-10 diagnoses is superseded by this BHIN, effective January 1, 2022, except for psychiatric inpatient hospital and psychiatric health facility services, which will be addressed in forthcoming guidance.

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Will ACBH require a review or sign-off of a Z-Code if used for an extended amount of time now that DHCS has indicated that there is no timeline or deadline for establishing a diagnosis but rather relying on the provider's clinical judgment?

The timeline to establish a diagnosis is dependent on the symptoms presented by the client. If a client meets criteria for a DSM-5 diagnosis, the provider should assign a diagnosis. If a client does not initially meet diagnostic criteria, but still meets access criteria for medical necessity, services may be provided using Z03.89 until the establishment of a diagnosis. Regarding reviews and sign-offs, CQRT is a required review to determine that treatment criteria is met, and that services target the client's symptoms and impairments as described on their problem list and are not fraud, waste, or abuse. Additionally, Scope of Practice guidelines dictate sign-off requirements for diagnoses.

Will diagnoses that were not previously on the included/billable lists now be allowed for access to SMHS services? Will ACBH provide a CMS approved diagnosis list?

Yes. The cessation of the included/billable lists will broaden the pool of acceptable diagnoses. However, there is still a requirement that SMHS providers only treat beneficiaries with moderate to severe mental health conditions and diagnoses must be consistent with this requirement. Some examples of exceptions were noted in the BHIN 21-073: "A neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a beneficiary meets criteria for access to the SMHS delivery system."

ACBH is awaiting a response from DHCS regarding whether there will be a list of specific diagnoses that will be excluded and will provide guidance to providers once a response is received. At this time there is no such list and as noted above, providers are expected to be mindful of which diagnosis would be in scope based on the SMHS access criteria. Providers who wish to do so, can continue using the current SMHS outpatient included list.

Can providers begin using ICD-10 codes for diagnoses not in the DSM-5?

ACBH has submitted a request for guidance to DHCS on this matter and is awaiting confirmation and direction. ACBH has yet to update any approved/included diagnoses lists in InSyst or CG.

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If a diagnosis is no longer required for access to SMHS, must an established diagnosis show documentation of DSM-5 signs and symptoms?

The flexibility introduced with the new access criteria was intended to provide a "no wrong door" experience. Diagnoses are still a standard of quality care and central to guiding treatment decisions; they will continue to play a pivotal role in treatment. DHCS is allowing Z-Code use for the limited cases in which a diagnosis cannot be immediately established. DSM-5 signs and symptoms should still be documented to support an assigned diagnosis.

The Documentation Requirements Draft BHIN outlines the requirements for assessments of beneficiaries 21 years and older in the SMHS system of care. The guidance provides an overview of documentation expectations as they relate to diagnoses:

Domain 7: Clinical Summary; ICD 10 Code; Medical Necessity Determination; Level of Care/Access Criteria (e.g., clinical impression, including etiology, clinical complexity, and impairments; predisposing, precipitating, perpetuating and protective factors; diagnosis/ICD-code consistent with presenting problems, history, mental status exam and/or other clinical data, including any current medical diagnosis; Capture diagnostic uncertainty (provisional or unspecified); service recommendations for the treatment episode; SMHS Access Criteria.

Will there be adjustments to the NOABD process if CBOs no longer have to diagnose?

No. 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 required for quality care. On the rare occasion that a beneficiary does not meet criteria for a diagnosis, services can still be provided using Z03.89 following the limitations of that ICD-10 code.

Youth can qualify for services based on their experience of trauma, regardless of whether they have a diagnosis, and DHCS has indicated youth who are at risk of a mental health condition can continue to receive services if the care is medically necessary, regardless of whether they ever receive a diagnosis. Does ACBH agree?

Yes. One of the indicators for establishing the criteria for beneficiary access (Medical Necessity) on admission and ongoing is that 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

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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 this is established, then criteria is met without a diagnosis. This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10 diagnosis code. DHCS recommends using options available in the CMS approved ICD-10 diagnosis code list, including "Other specified", "Unspecified" disorders," or "Factors influencing health status and contact with health services". (i.e., Z codes).

The guidance is not removing the requirement to provide a thorough assessment and the expectation would be that the treating provider is continuing to assess the beneficiary's condition and documenting a diagnosis if/once one is identified.

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?

"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." However, "a neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a beneficiary meets criteria for access to the SMHS delivery system."

The new guidance noted above allows providers to treat beneficiaries when there are co-occurring substance use issues. 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.

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 an 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

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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 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).

Does BHIN 21-073 change the clinical documentation timeline for STRTPs given that client 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 Short-TermResidential Therapeutic Programs (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, client plans are developed around a client's symptoms and functional impairments, which is often categorized into diagnostic criteria.

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, now referred to as "access criteria", 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.

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

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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. Please see below for access criteria for ACBH contracted CBOs:

Criteria for Beneficiaries under 21 years of age to Access the Specialty Mental Health Services Delivery System:

Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) or (2) below:

(1) *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.
OR
(2) The beneficiary meets both of the following requirements in a) and b), below:

a) The beneficiary has at least one of the following: i. A significant impairment ii. A reasonable probability of significant deterioration in an important area of life functioning iii. A reasonable probability of not progressing developmentally as appropriate. iv. *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
b) The beneficiary's condition as described in subparagraph (2) above is due to one of the following: i. A diagnosed mental health disorder, according to the criteria of the current editions of the DSM and the ICD. ii. *A suspected mental health disorder that has not yet been diagnosed.* iii. *Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.*

If treatment services can be provided before the Assessment and Client 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 Client Plan aren't completed until January 5th, would the services between December 31st and January 5th be disallowed if not waste, fraud, or abuse?

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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 Client Plan. The only disallowances will be based on fraud, waste or abuse. The State plans to disseminate their "Updated Annual Review Protocol and Reasons for Recoupment FY 2022-2023" document in October 2022 at which time we will have more clarity regarding the specific circumstances that would lead to disallowances.

Will ACBH allow clinicians to provide treatment services prior to the Assessment being completed and a Client Plan being developed?

Yes, however, treatment services need to be clinically appropriate, and covered mental health prevention, screening, assessment, treatment, or recovery services even when beginning prior to Assessment or Client Plan completion. Documentation is still of vital importance in demonstrating that clients are receiving quality, medically necessary services in line with best practices. DHCS has not yet provided ACBH with specific guidance related to the Quality items that should be noted in a chart, or any specific guidance related to recoupment (e.g., what is considered waste).

Will ACBH allow paraprofessionals to provide treatment services prior to the Assessment being completed and a Client Plan being developed?

There have been no changes to scope of practice requirements. As such, a professional of any type would need to be working within their scope of practice to provide medically necessary services both before and after Assessment and Client Plan completion.

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

After careful consideration, ACBH will no longer require the use of the Brief Screening Tool. DHCS is developing standardized screening tools with expected roll out in January 2023.

The DHCS has indicated that further guidance is forthcoming on state-approved 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?

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DHCS has identified several optional tools until further guidance can be provided. Trauma Screening Tools: 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 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.

Regarding CQRT, will we still be "authorizing" direct services post assessment? If not, when will these changes take place?

The CQRT process and checklist were recently modified to align to the new Access Criteria and reduce provider administrative burden. Please see updated documented on the Provider Website.

Will chart reviews and disallowances be suspended until a new chart review checklist can be developed that fully reflects the new eligibility guidance?

The State has not given counties permission to suspend or postpone audits of agencies. At this time, counties are required to continue with audits.

What is the plan to update the county policies impacted by the Cal-AIM changes, such as the Authorization for SMHS Policy or the Documentation Manual?

Appropriate revisions to current policy & procedure documents and manuals are underway. This will be an ongoing process as ACBH continues to seek guidance and clarification from DHCS and works closely with our external county partners. As updates are made and approved for publishing, they will be released. For more immediate guidance, please continue to utilize the Brown Bag Meetings as well as the QATA mailbox.

Does the BHIN and ACBH's memo supersede any contracts that are contrary to those directions?

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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.

Documentation Requirements

If a service not on the Client Plan is provided, will the Client Plan have to be updated even if the service is not expected to be needed regularly?

Currently that is the requirement, but this will likely change for services that will no longer require a Client Plan. Until those changes have been formalized, please continue to make updates to the Client Plan when new services are rendered.

Will a service be disallowed or billing recouped, if it is not reflected in the Client Plan?

No. 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.

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?

The current guidance related to this matter is in draft form. Once ACBH receives additional guidance, we will communicate updates to our CBO partners.

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Can we bill for ICC, IHBS, or 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 the Draft BHIN, citing, 42 C.F.R. § 440.169(d)(2) "Federal law requires a care plan for individuals receiving case management services. A care plan is required for Targeted Case Management services, including Intensive Care Coordination." ACBH has submitted a request for guidance to DHCS on this matter and is awaiting direction. Providers should follow the current process for authorization until further guidance is issued by the State. ICC, IHBS, and TFC services still require a client plan (care plan) for which an assessment must precede.