City and County of San Francisco
London N. Breed
Mayor

San Francisco Health Network
Behavioral Health Services

Frequently Asked Questions: California Advancing & Innovating Medi-Cal (CalAIM)

Version 1.0

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CalAIM FAQs

The following specific questions were sent from providers and administrators across the various system of care. This document can be used as a tool that summarizes frequently asked questions related to BHIN 22-019. Subsequent versions will be published regularly, pending clarity from DHCS requirements. Every provider should obtain the source document and follow the source documents referenced here.

SPECIALTY MENTAL HEALTH SERVICE PROVIDERS

(Note: Any responses that are relevant to DMC-ODS Providers will be noted in the questions)

SMHS General

1. **When are the new regulations effective? (Applicable to DMC-ODS Providers)**

   BHIN 22-019 makes CalAIM documentation changes effective July 1, 2022. This means BHS Compliance will not disallow for non-compliance with the previous standards.

2. **What ICD-10 codes should a provider use to claim for services provided to a client that has not yet received a diagnosis? (Applicable to DMC-ODS Providers)**

   Regarding BHSIN #21-073 guidance by DHCS and the changes effective January 1, 2022, a new Welfare and Institutions Code section 14184.402(f)(1)(A) clarifies that a mental health diagnosis is not a prerequisite for access to covered Specialty Mental Health Services (SMHS). **This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10 diagnosis code**.

   Per BHIN #22-013 guidance issued by DHCS, a provider may use the following Z codes during the assessment phase:

   - **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 phase*

   - **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* 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, LPHA may use any clinically appropriate ICD-10 code. For example, these include codes for "*Other specified*" and "*Unspecified disorders*" or *"Factors influencing health status and contact with health services (I.e., Z codes)*".

Please refer to:

- BHIN 22-073 for a review of Medical Necessity and Access Criteria: DHCS Criteria for Beneficiary Access & Medical Necessity, page 6.
- BHIN 22-013 (ca.gov) for Code Selection during Assessment Phase

3. How will documentation of referrals be captured? Will there be a template? (Applicable to DMC-ODS Providers)

Referrals will continue to be tracked via the Timely Access Log/CSI Assessment and Time to Psychiatry. Communication and training are forthcoming regarding Timely Access Log and CSI Assessment.

Note – DMC-ODS Providers do not have CSI Assessments

SMHS Access Criteria

1. What does Access Criteria mean?

For SMHS : "Access criteria" for individuals has been separated from "medical necessity for services". Please see revised medical necessity and access criteria below:

Criteria for Beneficiaries Under 21 to Access SMHS (Either Criteria 1 OR Criteria 2)
Criteria 1:
1. The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by <u>any</u> of the following: • Scoring in the high-risk range on a trauma screening tool approved by DHCS • Involvement in the Child Welfare System • Juvenile Justice involvement • Experiencing homelessness
OR
Criteria 2:

1. The beneficiary meets both of the following requirements in **a and b** below: a. The beneficiary has **at least one** of the following: • A significant impairment • A reasonable probability of significant deterioration in an important area of life functioning • A reasonable probability of not progressing as developmentally appropriate • A need for SMHS, 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 above is due to **one of the following**: • A diagnosed mental health disorder, according to criteria of the current editions of the DSM and ICD • A suspected mental health disorder that has not yet been diagnosed • Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional

No Wrong Door

1. Can you clarify the No Wrong Door Policy? Do we have to provide services to all clients who are referred?

The *No Wrong Door Policy* does not mean providers must serve every individual who requests services. If the clinic/provider is not contracted to provide the services being requested ***or*** if it is determined that the client would benefit from a different type of provider, the provider of first contact may assist the client in transitioning to a more appropriate provider based on the assessed needs. Until DHCS releases the standardized screening and transition tools, providers should continue to follow current screening procedures to determine if an individual will be served by their clinic/organization or if they should be referred to the Managed Care Plan (MCP).

Please refer to the DCHS No Wrong Door Policy and SF BHS No Wrong Door FAQ

- DHCS No Wrong Door for Mental Health Services Policy
- SF BHS No Wrong Door Policy
- SF BHS CalAIM No Wrong Door FAQ

2. What is being done to address the limited clinician availability? There are very few openings in CYF clinics in the city for SMHS services, and considerable need. During the pandemic at least, Beacon hit capacity as well for NSMHS: So what solutions are in motion to meet the demands given that CalAIM will provide more people with much needed access paths, particularly at the initial assessment stage?

The current national hiring crisis is an incredible challenge for everyone. The plan is to continue to address and identify solutions to the staffing issues while also aligning with CalAIM, which is intended to streamline processes and reduce the documentation burden on our staff. SF BHS will be partnering with the Managed Care Plans to coordinate efforts as all systems are focused on increasing capacity.

3. **Would we now be seeing children with an Autistic diagnosis and no other DSM diagnosis?**

   There is no longer an included list of DSM diagnoses. Clients must meet medical necessity and the access criteria in order to receive SMHS. However, clinicians must only provide services within their scope of practice. Since the treatment for Autism is a highly specialized practice and requires training, many providers will not be able to provide services if the only diagnosis is Autism Spectrum Disorder. However, the clinician may provide services if there is a secondary diagnosis and the services fall within their scope of practice.

   Please refer to DHCS CalAIM Documentation Requirements-BHIN 22-019 for more details.

4. **The door is also being opened for adolescents and children with substance abuse issues without other diagnoses. How will these changes increase the number of clients for the clinic?**

   The *No Wrong Door Policy* removes some of the barriers to immediate access, however, it does not require providers to serve every individual who reaches out for services.

   Placing the substance use or medical diagnosis as the primary diagnosis is not a cause for audit disallowance because this is what your assessment identified. Claims will not be denied if the ICD-10 diagnosis code associated to the claim is a substance use or medical diagnosis. However, if a client is assessed to only have an SUD diagnosis, they would be referred to an SUD provider as soon as the diagnosis has been established.

5. **Who is the managed care plan? What is the process for referral? (Beacon, SFHP, Anthem or others?)**

   The Managed Care Plans for SF County are Anthem and SFHP/Beacon.

Anthem: Referrals should be directed to Anthem's Behavioral Health Shared Mailed Box: bhcmreferrals@anthem.com by providing member information and a need for referral explanation.

SFHP/Beacon:
Beacon Health Options manages mild-to-moderate behavioral health benefits and Behavioral Health Therapy (BHT) benefits for all SFHP Medi-Cal members except members assigned to Kaiser Permanente. To refer a member for mental health services, call Beacon's toll-free Access Line at 1-855-371-8117. For information on Beacon referrals and the current screening tools: Mental Health - San Francisco Health Plan (sfhp.org)

6. **Will there be changes with Beacon or other MCPs to accommodate more referrals?**

   We will be partnering with the MCPs as much as possible to coordinate and collaborate on access for clients.

7. **Is there a separate unit that will be getting the authorizations or is it each clinic doing their own within the respective clinic?** ***Updated 10/28/2022***

   Most outpatient SMHS do not require authorization. Providers will follow the relevant SF BHS policy to obtain prior authorization for the following services: IHBS, TFC, TBS, STRTP's.

   CYF has updated the policy for prior authorization. The CYF UM Committee authorizes and tracks all IHBS, TFC, and TBS services. Please see the **Utilization Management Policy and Procedures for San Francisco County Children, Youth, & Families System of Care for *Intensive Care Coordination/ Intensive Home-Based Services and Therapeutic Foster Care*** effective 9-30-22.

8. **Will there be other changes to timelines for delivery of services?**

   We will continue to communicate and update providers regarding any additional changes or policy updates.

9. **Will this mean that the clinic sees more substance abuse clients? If so, what training will be provided?**

   SMHS providers are encouraged to assess substance use needs in order to ensure the most comprehensive treatment possible. However, 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. If a client 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.

10. What is the messaging to the community about what is being rolled out?

SF BHS is adopting and will be utilizing the CalMHSA CalAIM materials. These materials are publicly available and have information that is helpful for community members. We also encourage providers to share this information with clients whenever possible. https://www.calmhsa.org/wp-content/uploads/Beneficiary-CalAIM-Communication-Materials-7.15.22-v2.pdf

11. There is concern that changes will happen without sufficient training, yet expectations may be high about how to implement changes well.

BHS is in the process of creating materials, FAQs, and hiring a Training Coordinator. Providers may also contact the CYF Clinical Operations Manager with specific questions. We acknowledge that there are many changes related to this initiative and will work with our provider community to support each phase of the process with as much support and clarity as possible.

12. We have parents who can benefit from services, can we provide a new service for adult if their child is receiving services?

The *No Wrong Door Policy* does not mean providers must serve every individual who reaches out for services. SMHS providers must continue to provide services for the populations they are contracted for. Adult beneficiaries may not be open in CYF RUs.

Please refer to the DCHS No Wrong Door Policy and SF BHS No Wrong Door FAQ

- DHCS No Wrong Door for Mental Health Services Policy
- SF BHS No Wrong Door Policy
- SF BHS CalAIM No Wrong Door FAQ

13. What should we do for all other populations that aren't CYF regarding "no wrong door" CalAIM policy? Is the clinic expected to accept adult clients?

The *No Wrong Door Policy* does not mean providers must serve every individual who reaches out for services. Providers should refer to their contracts regarding who may receive services. If and when an individual cannot receive services at a particular clinic/organization, they should be given relevant resources and follow the typical standard of care.

Please refer to the DHCS No Wrong Door Policy and SF BHS No Wrong Door FAQ

- DHCS No Wrong Door for Mental Health Services Policy
- SF BHS No Wrong Door Policy
- SF BHS CalAIM No Wrong Door FAQ

SMHS Assessment

1. **What is the assessment period for Crisis Stabilization and Crisis Residential program?**

   There is no change to this requirement under CalAIM. Assessments are to be completed with-in 3 days for residential per BHS guidance.

2. **Can the Assessment be completed and finalized by an MHRS or RN/LVN with a Z-Code in residential treatment and Crisis Stabilization?**

   - **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 phase* and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP)

   - **ICD-10 code Z03.8L**: "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP *during the assessment phase*
   - In cases where services are provided due to a suspected disorder that has not yet been diagnosed, LPHA may use any clinically appropriate ICD-10 code . For example, these include codes for "*Other specified*" and "*Unspecified disorders*" or *"Factors influencing health status and contact with health services (I.e., Z codes).*"

   Please refer to:

   - BHIN 22-073 for a review of Medical Necessity and Access Criteria: DHCS Criteria for Beneficiary Access & Medical Necessity, page 6.
   - BHIN 22-013 (ca.gov) for Code Selection during Assessment Phase

3. **Can you provide clarity on the statement: "If the provider cannot complete the assessment within the time frame, clinical justification must be documented in client record (weekly) until the assessment is completed." Does this mean you need to enter a progress note with the clinical justification for late assessment, with ADM99? *Added 10/28/22***

   Our guidance is to document the clinical justification for continued Assessment beyond 60 days in an Assessment (ASMT1) note. Providers should document the clinical reason for the delay in a progress note at least weekly. Services may continue to be billed during this time.

ANSA and CANS

1. **How often will we need to complete the ANSA given that we are now completing the assessment at opening and every three years after that?**

   As for now ANSA will be completed with the initial assessment and every three years when re-assessment is completed. A discharge or closing ANSA will still be completed.

2. **Can we get an example of due date cadence for CANS? It would be helpful to see the due dates with an example. *Added 10/28/22***

   CANS Ratings are due every 6 months. Right now, the requirement is to complete the CANS ratings based on the episode opening date. The initial CANS ratings are to be done at least 6 months, but no more than 7 months from the episode opening. If the episode opening date is 10/1/2022, the 6-months CANS would be completed starting on 4/1/2023, but no later than 5/1/2023.

   The Annual CANS Assessment is completed by the Anniversary Date and every 6-months thereafter.

SMHS Diagnosis

1. **For clients who are accessing care through medical necessity's Criteria 1 (trauma screen/child welfare/juvenile justice/homelessness), how will the diagnosis work at the 60-day mark? Do they still need a formalized diagnosis? Do we use the suspected dx/z-codes instead? How long can that last?**

   Regarding BHIN #21-073 and the changes effective January 1, 2022, a new Welfare and Institutions Code section 14184.402(f)(1)(A) clarifies that a mental health diagnosis is not a prerequisite for access to covered Specialty Mental Health Services (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, options are available in the CMS approved ICD-10 diagnosis code list. For example, these include codes for "Other specified" and "Unspecified disorders". (DHCS Criteria for Beneficiary Access & Medical Necessity, page 6).

   As long as there is an ICD-10 diagnosis per the code list, there is no time limit. For example, a client who is involved in the Child Welfare system ***AND*** is assessed with an "Other Specified" diagnosis may maintain that diagnosis for the duration of services.

2. **What is the timeframe for getting the final diagnosis?**

   The Assessment, including the diagnosis, is due no later than 60 days from client opening date or as soon as a final diagnosis is determined. If providers cannot complete initial assessments within 60 days, efforts to complete it within a clinically reasonably timeframe should be documented in a progress note (at least weekly) in accordance with generally accepted standards of practice.

   For DMC-OD:
   1. Residential providers should provide a diagnosis based "SUD LOC" prior to admission.
   2. For youth clients under 21 years receiving services from an adult Medi-Cal Contract and for adults over 21 years of age, the diagnosis is due within 30 days from opening date. For adults experiencing homelessness the provider has 60 days to identify a diagnosis
   3. For youth clients under the age of 21 receiving Drug Medi-Cal services under the EPSTD mandate, the diagnosis is due within 60 days from opening date.

3. **Crisis Stabilization is a 23-hour program. At what point is the diagnosis supposed to be completed for billing.**

   No changes regarding CalAIM. BHS standard guidance still applies.

SMHS Problem List

1. **Consider calling the "problem list" a "barrier list" to utilize more strengths-based language. (Applicable to DMC-ODS Providers)**

   DHCS is using the term "problem list" to align with physical health care system language, keeping in mind the goals of care coordination and integration. It is acknowledged that the term "problem list" may not reflect the collective vision for strength-based care. BHS will gather additional feedback and input on the name of the form to be addressed in future phases of our implementation.

   https://www.dhcs.ca.gov/Documents/BH-Doc-Redesign-PPT-5-26.pdf, page 9

2. **Do all clients require a Problem List? (Applicable to DMC-ODS Providers)**

   Yes. All clients will require a Problem List moving forward. Providers will complete the Problem List as soon as it is available in Avatar and when it is clinically appropriate or when the next treatment plan is due. Services that require a Care Plan, also require a Problem List.

3. **When will we see a template? When will we know more about how to do the change? (Applicable to DMC-ODS Providers)**

   BHS is working on the availability of a Problem List as quickly as possible. The anticipated roll out is in early October 2022 and to be determined for DMC-ODS. A proposed template is located in the CALMHSA Documentation Manual on page 19, https://www.calmhsa.org/wp-content/uploads/CalMHSA-MHP-LPHA-Documentation-Guide-05182022.pdf.

4. **Problem List – does every "problem" or item on the Problem List need to be attached to an ICD-10 or Z code? (Applicable to DMC-ODS Providers)**

   Everything on the Problem list WILL have a corresponding ICD10 code. 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. Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when 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.

Per DHCS CalAIM Documentation Requirements-BHIN 22-019, page 5.

5. What are appropriate problems to add to the problem list? (Applicable to DMC-ODS Providers)

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.
- Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
- Problems identified by a provider acting within their scope of practice, if any (include ICD-10 Code)
- Problems or illnesses identified by the beneficiary and/or significant support person, if any (include ICD-10 Code).

There is no required timeframe to update the problem list or requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers should update the problem list within a reasonable time and in accordance with generally accepted standards of practice.

6. Whenever the problem list is added or changed, should a "TCM" note be entered? *Added 10/28/22*

Regarding the Problem List, if there are changes to the Problem List, a provider may document those changes and reasons why in a standard progress note and bill the service as Plan Development or Assessment, depending on the activities during the session/encounter/service.

Regarding TCM, the clinical practice of billing and delivering TCM has not changed. If there

are new TCM needs and/or goals that need to be addressed, the provider would create an updated TCM Care Plan and bill the service as TCM.

7. **When the diagnosis page is completed, it will automatically populate the Problem List, or do we have to enter it into the problem list?** ***Added 10/28/22***

   Yes, when you enter the diagnosis, you click a box to 'push', or add, the problem to the Problem List.

8. **Can we phase in implementation of problem list with new cases and continue referring to the TPOC for older cases until TPOC expires?** ***Added 10/28/22***

   Yes, we advise to implement the Problem List with all new cases *and* cases that have relevant diagnostic updates. The TPOC can be phased out of the client's chart as the treatment period expires.

9. **Interestingly, it seems like the Problem List for my clients was automatically generated already because I had previously selected "add to problem list" when I did Dx.** ***Added 10/28/22***

   Yes! If you have been clicking that 'add to Problem List' button on the Diagnosis form, then your problem list is already populated!

10. **If there was an error in how one of my Problem Lists was generated (eg it included Dx from a previous episode and incorrectly attributed them to me), do you know who I contact or what to do with that?** ***Added 10/28/22***

    Contact the Avatar helpdesk and open a ticket. It's important that the Avatar Helpdesk has this information, including how pervasive the issues are. Every ticket helps advance the progress to resolving technical issues.

11. **Is there a document that includes all of the different options that can be used for the problem list? It would be helpful for staff to refer to when creating a problem list.** ***Added 10/28/22***

    The Problem List is created by using the Diagnosis form in Avatar. So, any diagnosis that is within one's scope to diagnose can be entered there. Please see the following sources for additional details:

- CalMHSA Documentation Manual page 15:https://www.calmhsa.org/wp-content/uploads/CalMHSA-MHP-LPHA-Documentation-Guide-06232022.pdf
- Code Selection During Assessment Period for Outpatient SMHS: BHIN 22-013 (ca.gov)

SMHS Care Plan

1. **What does it mean that ICC and IHBS will still need a standalone Care Plan? Does that mean they will still require the same TPOC that we are using now?** ***Updated 10/28/22***

   SF BHS released (10/15/2022) a simplified Care Plan in Avatar that will meet the requirements for ICC, IHBS, and TFC. The Care Plan is created in the Care Plan progress note template and replaces the TPOC.

   Please refer to DHCS CalAIM Documentation Requirements-BHIN 22-019 page 12:
   - Intensive Care Coordination (ICC) requires compliance with the cited Federal rules.
   - Intensive Home-Based Services (IBHS) and Therapeutic Foster Care (TFC) services for Medi-Cal Beneficiaries require a client plan.
   - Therapeutic Behavioral Services (TBS) require a client plan.

2. **Will the removal of TPOC come with the expectation that we see more clients (will caseloads go up) because there will be slightly less time expected to be spent on documentation?**

   The clinical decision-making regarding caseloads and service delivery remains separate from the requirement for a TPOC. One of the goals of CalAIM is to reduce the burden on providers related to documentation and chart requirements so that providers may focus more on the quality of care and client needs. The decisions on caseloads will need to be made by organizations.

3. **In the *CYF Aligning with CalAIM Materials*: Improving Access and Documentation Reform PowerPoint, slide 19 indicates that a "Client signature [is] not required for Care Plan," but doesn't specify if the authorized representative's signature is also not required anymore. Is the auth rep signature also no longer required?**

   There is no indication from DHCS, or 42CFR, indicating that a signature from the provider is required on the Care Plan. 42 CFR does require: the name of the provider agency (if relevant) and the person providing the case management service.

However, if the Care Plan is located in a Progress Note then the signature of the provider would be required. Progress Notes require: "A typed or legibly printed name, signature of the service provider and date of signature", per Behavioral Health Information Notice No: 22-019.

At this time, we are continuing to require that a TPOC be finalized in Avatar, as the Problem List and Care Plan are not yet operational in Avatar. Please adhere to previous guidance regarding TPOC requirements. We will issue further guidance regarding the Problem List and Care Plan requirements when the TPOC is no longer active in Avatar.

We anticipate the Problem List will be released in mid-October 2022 and the Care Plan Template at the end of October 2022.

4. **If our clients are receiving medication support services, this intervention is added to the current team's treatment plan by the clinician. Does the psychiatry provider need to sign the treatment plan?**

   No, the Psychiatrist would not need be required to sign the treatment plan in this situation.

5. **Tracking Client Plans in AVATAR- We look forward to being able to embed client plans in progress notes rather than as separate TPOCs, but wonder whether there is an efficient way to track whether the plan has been done?** ***Updated 10/28/22***

   A Care Plan embedded in a Progress Note template is now available. That means, providers will be able to complete the Care Plan for TCM, ICC, IHBS, and TFC in a specific progress note type. This will allow providers to easily track and refer to the document as needed.

6. **If there are existing treatment plans that have not expired yet, do these need to be entered as a progress note care plan?** ***Added 10/28/22***

   System of care managers have reported that current unexpired care plans are fine for now. If you need to update or change the plan, then you should use the new progress note care plan.

7. **If a treatment plan expires shortly, and there is no change in problem list, goals or interventions, what details should I include in the progress note?** ***Added 10/28/22***

When current Care Plans expire, then a new Care Plan should be documented using the new care plan template provided in Avatar. An updated Care Plan using the new format should be completed when previous treatment plans expire. The progress note would highlight the review of the Problem List and the plan to move forward.

8. **If there are changes to the problem list, goals or interventions, what details should I include in the progress note? *Added 10/28/22***

   Providers should update a problem list as needed. Changes to goals and interventions should be documented in a new Care Plan note. If a current care plan expires, then providers should complete/update the client's care plan using the new care plan template. The progress note to document this service would highlight the changes made, reasons why, and plan to move forward. See CalMHSA Manual pg 36 for an example progress note: https://www.calmhsa.org/wp-content/uploads/CalMHSA-MHP-LPHA-Documentation-Guide-06232022.pdf

9. **While waiting for appropriate samples of progress note templates for care plans, can we complete the existing treatment plan form? *Added 10/28/22***

   Progress note templates for care plans are currently in Avatar. Providers using Avatar can currently access care plan templates.

10. **Now that the treatment plan is no longer required, does the Client Service Authorization (CSA) and PURQC form need to be completed? The CSA form asks for the number of impairments based on the previous TPOC form. *Added 10/28/22***

    BHS Leadership will provide guidance about the required approach.

11. **The TCM Care Plan template in Avatar looks similar to the Treatment Plan of Care in Avatar that we were using until recently. Is there a timeline requirement to update it annually? *Added 10/28/22***

    Yes, that's right! The TCM Care Plan does look like the requirements that we previously used for the TPOC. Please refer to BHIN 22-019: There is no timeline to update the Care Plan. However, the Care Plan should be updated to reflect new goals and treatment activities as they change.

12. **If our agency utilizes our own Electronic Health Record for progress notes, are we**

required to create a Care Plan note template as well or could we create a separate form for the Care Plan for those services that require it? *Added 10/28/22*

We are asking that all providers create required Care Plans in Avatar. The current solution, as an alternative to the TPOC in Avatar, is the Care Plan created in a progress note template. These documents function as Care Plans and meet State/Federal requirements for these services. Because Care Plans are important for communication and are reviewed for clinical quality and authorization purposes, providers are required to ensure they are entered into the SF County Avatar system.

13. **Confirming we can just ignore the TPOC form that is still there? We want official permission that we can ignore it. *Added 10/28/22***

    The TPOC is not necessary anymore for SMHS. However, if you are providing TCM, ICC, IHBS, or TFC then you will need to do a Care Plan in a Care Plan Progress Note Template.

14. **Where does the TCM care plan go in Avatar? In the progress note section? Does it get billed as plan development note? *Added 10/28/22***

    The TCM Care Plan goes in the "TCM Care Plan Progress Note template" in Avatar. Providers may claim for TCM when developing the TCM Care Plan. See the Avatar Guide for assistance in creating the Care Plans

15. **Who can write a care plan? Does it need to be a LPHA? Can a MHRS or MHW write a care plan? *Added 10/28/22***

    Please refer to the billing matrix for billing privileges.
    https://www.sfdph.org/dph/files/CBHSdocs/SMHS_Desk_Reference.pdf

16. **If we do case management as part of our clinical therapy cases, do we need to do a TCM care plan? *Added 10/28/22***

    Yes. If you are intending to provide a TCM service, then you would need a TCM Care Plan in a progress note.

17. **Is the purpose of the Care Plan TCM note to indicate the intervention of Case Management Service (ie: replacing the function that was via TPOC)? *Added 10/28/22***

That is correct! In the past, all SMHS services (therapy, collateral, case management, etc.) all required a TPOC. The State no longer requires a TPOC for most services. However, due to other State and Federal regulations, some services still require a Care Plan. Per DHCS guidance, the TCM Care Plan is to be documented in a progress note. SF BHS has created a TCM Care Plan in a progress note template so that providers may find the note and refer to it as needed.

18. **Can one note indicate Case Management in general, as something like "coordination of care with other providers". Or, do we need to make one care plan for each provider that will be coordinating care (such as one with school staff, one with CPS workers, one with a Probation officer, etc.)? *Added 10/28/22***

    One TCM Care Plan would be sufficient for all activities as long as they meet the prompts and requirements for a Care Plan.

19. **Because the TCM Care Plan is entered to indicate that there is a service plan for case management, FTF will be 0 minutes, is that correct? *Added 10/28/22***

    There would be no FTF time in developing a Care Plan and entering it into Avatar.

20. **Should the Care Plan have any FTF time? Can we bill Doc/Trav for the time to write up the Care Plan, and bill "Targeted Case Management" or perhaps “Plan Development”? *Added 10/28/22***

    Correct. You would indicate the time spent writing and entering the Care Plan progress note in the Doc/Trav field and then bill TCM.

21. **How long can a Care Plan stay effective? In other words, do we renew annually, or can it stay effective until the closure of the episode (with the understanding that a revision/addition is needed when the objective/goal/plan changes)? *Added 10/28/22***

    The Care Plan is effective for as long as there is a need for the service. If there are significant updates to the service, then an update would be warranted.

SMHS Progress Notes

1. **At what point is a daily note considered late? In the current documentation manual, there is a window of 5 days and after 5 days, the notes should indicate Late Entry. Will there be Late Entry provision in progress notes? (Applicable to DMC-ODS Providers)**

   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. A note for a crisis service should be completed within 24 hours of service.

2. **What is the expectation on "final" in progress notes with regards to Co-signatures for group notes? (Applicable to DMC-ODS Providers)**

   For groups facilitated by multiple practitioners, a single progress note signed by one of the practitioners shall be used to document the group service provided. All progress notes should be finalized in three business days.

3. **Has there been a change to TCM services and billing? Should we bill "case management" services differently? For example, the coordination of care with other providers. *Added 10/28/22***

   TCM services have not changed.

4. **Given CalAIM documentation changes, should we not do BIRP/PIRP notes anymore? *Added 10/28/22***

   No. We hope that all clinics and programs do everything possible to reduce the burden of progress notes on staff and to focus on the key elements. See pg. 26 of the CalMHSA manual for additional information on progress note requirements: https://www.calmhsa.org/wp-content/uploads/CalMHSA-MHP-LPHA-Documentation-Guide-06232022.pdf

5. **Once a TCM Care Plan is created, at the time of providing TCM service, we are to write a progress note as a regular progress note, NOT care plan template, correct? *Added 10/28/22***

Yes, that is correct. After the creation of the TCM Care Plan, please indicate and bill for TCM services using the "General Progress Notes Template".

6. **Does a standalone plan have to be created prior to the provision of TCM service claims? If so, do we continue using the Avatar MH progress note template to document TCM notes? Would we need to update this care plan? Would we bill Care Plan as Plan Development H0032 or TCM 1017?** ***Added 10/28/22***

   When you are assessing the TCM needs and/or developing a Care Plan for TCM services, you may claim TCM T1017. Once it is determined you will provide ongoing TCM services (e.g., monitoring and follow up, ongoing referral and linkage) providers will create a TCM Care Plan, which is now in a progress note template, which will serve as the required Care Plan for subsequent TCM services. The development of the TCM Care Plan may be billed as TCM T1017. You will need to create a new Care Plan when and if it is determined that there are changes to the goals/objectives. There is no expiration on the Care Plan.

   The subsequent TCM services will be documented in progress notes in the same way you have always done, that is, you will write a progress note (General Progress Note template) for the service and code it as TCM.

SMHS Documentation

1. **Will clients have more access to our notes and documentation? What is the impact of clients being able to view notes more easily?**

   Clients and caregivers do have rights to their charts under the 21st Century Cures Act, which is separate from the CalAIM initiative. Research has shown that, in mental health care, the use of a patient portal can have a positive effect on patient activation, recovery, and organizational efficiency. Please contact Clinical Operations for more information.

SMHS Discharge

1. **What happens when a client discharges from the Program and there is only a Z-Code? (Applicable to DMC-ODS Providers)**
   If client discharges early or before 60-days, then a Z-code or preliminary diagnosis is the final diagnosis.

2. **How will closing assessments/closing procedures be implemented under the new CalAIM documentation reform? (Applicable to DMC-ODS Providers)**

   No changes regarding Cal Aim. BHS standard guidance still applies.

SMHS Medication-Mostly ("Meds-Mostly")

1. **What are the changes to documentation requirements for A/OA and TAY SOCs regarding Meds-Mostly treatment?**

   With the change in documentation requirements with CalAIM, A/OA & TAY SOCs are trying to decrease the paperwork burden on providers. In order for a client to meet the criteria of "meds mostly," the following guidelines should be met (Source: OCPA-BHSCO & BHS Medical Director):

   - Meets medical necessity: The client must meet medical necessity criteria for continued services.
   - Clinically stable: The client's mental health condition (impairment) and symptoms have been stabilized with psychiatric medication, and the client does not present with significant safety concerns or risk factors. The client's mental health needs are met through periodic visits.
   - Functionally stable: The client has reached their recovery goals and their desired level of functioning in their community.
   - Prevention of deterioration: The client needs to receive psychiatric medications to maintain their improvements in community functioning and to prevent significant deterioration in functioning.
   - Complex and specialized medication regimen: The client's medication regimen is sufficiently complex/specialized, and a Primary Care provider is unable to effectively prescribe and monitor the medication and the client's mental health status, and/or the client requires specialty level care in documenting a continued disability.

   Additionally, Meds Mostly cases may be cases where a clinician at another clinic is providing therapy and case management, and the A/OA or TAY Psychiatrist in another program is providing medication support services.

2. **What are the Meds-Mostly guidelines for staffing, services, and documentation workflow?**

For a meds-mostly client, the prescriber holds full case responsibility. The prescriber's name should be used as the "Admitting Practitioner" field of Avatar, BHS' current electronic health record. For a meds-mostly client no TPOC is needed. Additionally, there is no ANSA required.

Targeted Case Management (TCM) needs to have a "Care Plan" note type and the following details in the Care Plan progress note:

- 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
- Includes development of a transition plan when a beneficiary has achieved the goals of the care plan (BHIN Num22-019).

Given the meds-mostly criteria described above, the amount, frequency, and duration of TCM is expected to be minimal. A prescriber may create a care plan that refers a client to a case manager, health worker or peer for a specific case management need.

The meds-mostly guidelines require the client to have achieved clinical stability and recovery goals—it is expected that the focus of psychiatric care is prevention of significant deterioration in functioning. An E&M Psychiatric Service will be conducted at psychiatric visits, and if there is a change in the client's current status and the medical necessity criteria (i.e., prevention of significant deterioration in functioning), appropriate referral back to a clinician and change from "Meds Mostly" status may be indicated. For example, the client experiences a deterioration in functioning, needs crisis intervention, or additional supports beyond periodic medication support services and targeted case management. In this case, the admitting practitioner would be changed from prescriber back to a clinician and the client would no longer be "meds mostly."

3. **What are the changes for CYF Meds-Mostly cases?**

Within CYF SOC, most clients have a clinician supporting the case along with a psychiatrist. CYF Meds-Mostly clients are those that are either referred from a different organization, that does not have a prescriber on staff, to a civil service clinic for only medication support services, or those who have completed individual therapy and

treatment goals at a CYF clinic and can be maintained on periodic medication appointments. When primary care is unable to provide medication services, the CYF prescriber will manage these Meds-Mostly clients. With CalAIM documentation changes, CYF Meds-Mostly clients no longer need a treatment plan of care, and after the initial psychiatric assessment is completed, no longer need an annual psychiatric assessment.

4. **How to transfer a client to Meds-Mostly services within the CYF clinic?**

   In the CYF clinic, the clinician and the prescriber come to an agreement that the client and family have reached their treatment goals, and the client only requires ongoing medication support services. The prescriber is unable to transfer the client to primary care. The clinician will document in a progress note that the client, family and prescriber are in agreement with moving to medication mostly services.
   - Prescriber is changed to the admitting clinician in Avatar.
   - An E&M psychiatric service will be conducted at least annually.

5. **How to transfer a client from Meds-Mostly to restart therapy services at CYF clinic?**

   If there is a change in the client's status and medical necessity criteria, referral back to a clinician for therapy services may be indicated. For example, the client experiences a deterioration in functioning, needs crisis intervention, or additional supports.

   Prescriber will notify the program director that the client needs therapy services again, and will document in a progress note that the client, family and prescriber are in agreement.
   - Prescriber can update the Problem List if appropriate.
   - New clinician will become the admitting clinician in Avatar.

6. **What is the required documentation for CYF Meds-Mostly clients?**
   - Initial Problem List and updates to Problem List
   - Initial Psychiatric Assessment Summary completed within 60 days of opening
   - Initial and annual medication consent form
   - Annual vitals signs documented
   - CANS MD: Every 6 months. If mid-year, after 6 months from anniversary date and before 7 months. Prescriber does not need to complete if another agency is completing the CANS.
   - PSC-35: every 6 months. If mid-year, after 6 months from anniversary date and before 7 months. Prescriber does not need to complete if another agency is completing the PSC-35.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM PROVIDERS

SUD - General Questions

1. **What part of 22-019 applies to SUD residential services?**

   Per BHIN 22-019, SUD residential service providers do not have 30 days to complete the full assessment. Residential service providers should continue to do an ASAM based level of care assessment prior to admission. Providers can discontinue the use of the Treatment Plan of Care and use the Problem List instead. Providers shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition. Additionally, residential providers shall abide by new progress note requirements.

2. **What part of 22-019 applies to OTP? *Updated 10/28/22***

   Opiate Treatment programs are exempt from BHIN 22-19. Attachment 1 of BHIN 22-019 includes regulations that remain in effect including the federal requirements for Narcotic Treatment Program treatment plans. No part of 22-019 applies to OTP. OTP's should continue to use an ASAM-based assessment.

3. **When are the new regulations effective?**

   BHIN 22-019 makes CalAIM documentation changes effective July 1, 2022. This means BHS Compliance will not disallow for non-compliance with the previous standards.

   BHS is working to implement Avatar changes in phases. The SUD Avatar changes include Phase 1, adult assessment form update and progress note templates; Phase 2, youth assessment form update; and Phase 3, SUD Problem List. Counties are currently awaiting Netsmart changes that will provide protection for compliance with CFR 42, Part 2 when entering on to the Problem List

SUD - Diagnosis

1. **Do I still have to enter a diagnosis for every new DMC-ODS case I open?**

   Yes. This practice will continue until further notice. Provider must insert diagnostic code as admission diagnosis in Avatar or write a diagnosis in the episode opening form. A suspected diagnosis can be used until completion of the assessment.

2. **Can providers bill for "services" with a suspected diagnosis?**

Yes, Providers can bill for planned services with a suspected diagnosis. The services provided during the assessment period can be reimbursable up to 30 days from first visit for clients over the age of 21 and up to 60 days for clients under 21 or if homeless (when appropriately delivered within the scope of practice; when appropriately documented; when delivered to address a suspected SUD; whether or not the client ends up meeting criteria for medical necessity at the time of the completion of the assessment).

See response in section SMHS General FAQ#2 for more information

3. Can we open an episode with a Z code or deferred diagnosis and claim to Medi-Cal? Can we implement the Z code now?

Yes, an episode or clinical record may be opened with a deferred diagnosis (Z03.89), ICD-10 codes Z55-Z65, and any other clinically appropriate ICD 10 diagnosis code from the approved list. All claims must have a valid ICD-10 diagnosis code.

Yes, Z codes can be implemented now.

Please refer to:

Behavioral Health Information Notice: 22-013: https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf)

See response in section SMHS General FAQ#2 for more information

4. If a youth client is receiving SUD services under EPSDT, is the written narrative for medical necessity still necessary?

Yes, a written narrative for medical necessity is still necessary for youth under 21 years of age receiving SUD services through the DMC-ODS system. The definition of medical necessity for youth continues to be different than for adults. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate, which funds Drug Medi-Cal services for youth under 21, provides all appropriate and medically necessary services needed to correct and ameliorate substance misuse or substance use disorders.

Medical Necessity for youth under 21 years of age is defined as:

i. An adolescent has one covered diagnosis from the DSM for Substance Related and

Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, or is assessed to be at risk for developing a substance use disorder; and

ii. An adolescent meets the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

iii. The same standard is adopted for youth SUD treatment services funded by SABG. Children, Youth, and Family Services (CYF) is also exploring screeners to help determine whether youth may qualify for full ASAM assessment.

SUD - Assessment

1. **Are DMC-ODS services provided during the assessment period reimbursable when it is determined at the end of the assessment that the client does not meet criteria for Substance Use Disorder Services?**

   Yes, DMC-ODS services provided during assessment period are reimbursable whether or not the client ends up meeting criteria at the completion of the assessment. Covered and clinically appropriate services are reimbursable up to 30 days from first visit for clients over the age of 21 and up to 60 days for clients under 21 or if homeless. The clinical documentation should support why billed services were rendered during the assessment period.

   (This does not apply to DMC-ODS Residential or Opioid Treatment services).

2. **Is SFDPH removing the requirement to use the Addiction Severity Index (ASI)?**

   Yes, per BHIN 22-019, DMC-ODS providers must use an American Society of Addiction Medicine (ASAM) Criteria assessment for DMC-ODS beneficiaries. The SUD LOC form went live in Avatar, September 1st, providers should discontinue use of the ASI. The new assessment shall include the provider's determination of medical necessity and recommendation for services.

3. **Where are we documenting the ASAM assessment on AVATAR?**

   Effective September 1st, 2022, the form currently known as the "SUD LOC" will have been updated so that it could be used as an ASAM based full assessment. Clinicians should utilize the current SUD LOC form to document the full assessment.

4. **The ASAM assessment must be redone if the condition of the beneficiary changes. What life events/significant changes would require a reassessment using the ASAM criteria?**

According to MHSUDS INFORMATION NOTICE NO.: 17-040, a change in condition includes, "...a beneficiary who has never been suicidal makes a suicide attempt; or, a beneficiary who regularly participates in client plan services suddenly stops coming to appointments. Major life events that might lead to a change in the beneficiary's condition include, but are not limited to: job loss, birth of a child, death of a family member or significant other, change in relationship status (such as divorce), change in residence/living situation."

For SUD clients, a significant change constitutes a change in substance use patterns, significant change in baseline functioning, change in diagnosis, and drug of choice. For example, while in treatment it is discovered a client has a second substance that they are using and they did not disclose, and their condition worsens. Any significant change in usage severity or improvement, which may place a client at a different ASAM level of care, would require a reassessment. Transitioning across levels of care and moving from perinatal to non-perinatal may require a reassessment.

Further, if a client withdraws from treatment prior to completing the ASAM Criteria assessment and if later returns after 30 days from last contact, the time period starts over.

5. **How long do I have to document the SUD LOC, comprehensive assessment?**

   The 72 hours to complete the ASAM based "SUD LOC" for outpatient services or OTP is no longer required.

   Residential providers should continue to do an initial ASAM based "SUD LOC" prior to admission.

   For youth clients under 21 years receiving services from an adult Medi-Cal Contract and for adults over 21 years of age, the assessment is due within 30 days from opening date. For adults experiencing homelessness the provider has 60 days to complete the assessment.

   For youth clients under the age of 21 receiving Drug Medi-Cal services under the EPSTD mandate, the assessment is due within 60 days from opening date.

6. **My client is homeless and is having difficulty making sessions. DHCS has allowed 60 days to conduct the assessment, do I also have 60 days to complete the CalOMS admission?**

   The requirements for CalOMS remain in effect. The best practice is to complete the initial CalOMS within 30 days of the admission.

SUD - Treatment Plan of Care and Problem List

1. **Are treatment plans required for any SUD services?**

   Under BHIN 22-019, the only care planning requirement for DMC-ODS services is for peer support services and Narcotic Treatment Programs (NTP). Peer support services must be based on an approved plan of care. The plan of care for Peer Support Services must be documented within the progress notes. For NTPs, federal law still requires a standalone treatment plan.

   Until further notice, programs co-currently receiving funding from the Substance Abuse Prevention and Treatment Block Grant (SABG) will be required to have a care plan in addition to the Problem List.

2. **If we have our own electronic record, can we move forward with the problem list change?**

   Yes, providers with their own EHR should make changes as soon as possible. Please consult with BHS regarding confidentiality and privacy parameters required from CFR 42, Part 2.

3. **When will the Problem List be live in Avatar?**

   BHS is awaiting Netsmart to create functionality that prohibits viewing of CFR 42, Part 2, protected diagnosis. This is set to roll out in Phase 3 of Avatar changes. SUD providers should continue to use the Treatment Plan of Care until the Problem List is live.

4. **If a beneficiary has not had a physical exam in the last year, does the goal to have a physical exam belong somewhere in the beneficiary's file?**

   DHCS has stated that a physical exam goal does not need to be documented in a progress note or on the problem list if the client has not had a physical exam completed in the last 12 months. If it is a problem the beneficiary wants to work on it should be documented appropriately.

5. **When is the Problem List Due?**
   Providers will complete the Problem List as soon as it is available in Avatar/EHR and when it is clinically appropriate or when the next care plan is due.

The Problem List should be regularly maintained to reflect the youth's current functioning.

See responses in section SMHS Problem List for more information

SUD Progress Notes

1. **Are there changes to the progress notes deadlines for SUD?**

   Yes, the due dates for progress notes have changed. Routine outpatient services are due within 3 business days of service provision. Crisis Service notes continue to be due within 24-hours. Daily notes are required for services billed on a daily basis, such as residential treatment or day treatment. Weekly summaries are no longer required for day treatment or day rehabilitation.

   For late notes, the practice of writing that it is a late note and explaining the reason continues.

See responses in section SMHS Progress Notes for more information

SUD Utilization Management

1. **Do we need to issue an NOABD if the client does not meet criteria to access DMC-ODS and/or if it is determined DMC-ODS services would not be medically necessary?**

   Yes. If DMC-ODS services will not be provided, a Notice of Adverse Benefit Determination will need to be issued.

   We encourage all staff to review the materials published by CalMHSA: https://www.calmhsa.org/wp-content/uploads/Staff-CalAIM-Communication-Materials-06212022.pdf

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