Los Angeles County Department of Mental Health
Quality Assurance Unit

New Criteria to Access Specialty Mental Health Services (SMHS) & Medical Necessity Frequently Asked Questions

QA BULLETINS

- ✓ 21:07 CalAIM- An Overview
- ✓ 21-08: Updated Criteria to Access SMHS

Link to training video on the new criteria to access SMHS:
http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=9640

New Criteria and Medical Necessity

1. Do the CalAIM Access Criteria and Medical Necessity updates apply to all programs including Wraparound and Full Service Partnerships (FSP)?

   Yes. The updated criteria apply to all clients for all programs that may claim to Medi-Cal. This includes indigent clients who are seen within a program that has Medi-Cal funding.

2. Given there are no longer "included" diagnoses, are we expected to now treat everything?

   No. While there is no longer a specific "included" diagnosis list and there are new avenues to access SMHS beyond having a diagnosed mental health disorder, LACDMH and its providers are still mental health providers and the services provided through SMHS is not expanding. Managed Care Plans are responsible for treating conditions due solely to a medical condition. In addition, neurocognitive or substance-related and addictive disorders are not considered "mental health disorders" for the purpose of meeting criteria to access SMHS.

3. One of the new criteria for beneficiaries under 21 states "significant trauma placing them at risk of a future mental health condition, based on the assessment of a licensed mental health professional", does this mean that registered/waivered and/or student practitioners can no longer assess?

   No. There has been no change in the requirements related to which practitioners can conduct an assessment (i.e., licensed, registered, waivered and students with co-signature). LACDMH's current position based on communications with other counties and advocacy groups is that the requirement for the assessment of trauma is no different than the requirement to provide a diagnostic assessment in general. If further guidance from DHCS is provided, LACDMH will notify providers.

4. Can practitioners move forward with the trauma criteria for beneficiaries under 21 without the approved screening tool?

   At this time, DHCS has not yet approved a trauma screening tool. However, practitioners within scope to provide a diagnosis can determine if the beneficiary is at risk for a mental health disorder due to trauma using the other conditions listed in Criteria 1 (i.e. involvement in the Child Welfare System, Juvenile Justice Involvement, and experiencing homelessness), or if the beneficiary's condition is due to significant trauma based on their clinical judgment.

5. If clients 21 and over do not demonstrate "significant impairment" leading to a diagnosis, can they still meet criteria to access SMHS?

Yes. For clients 21 and over, the criteria to access SMHS is either significant impairment or "a reasonable probability of significant deterioration in an important area of life functioning". Under the reasonable probability of significant deterioration criteria, the client may qualify if they currently do not have significant impairments but given their psychiatric history, there is a reasonable risk they may experience significant impairments without treatment.

6. Once the assessment has been completed and the client meets criteria to access SMHS but we feel the client doesn't need any specific SMHS at this time (e.g. they do not have any symptoms or other indicators that treatment is needed), what should we do?

   This question illustrates the difference between criteria to access SMHS which applies to a person (i.e. is this person eligible to receive SMHS?) and medical necessity which applies to the service (i.e. is the service provided clinically appropriate?). Receiving SMHS is a two part question: a) does the individual qualify to access the services and b) are SMHS clinically indicated. Practitioners always have the discretion of determining clinically appropriate services and do not have to provide services that are not clinically appropriate. If it is determined that the individual does qualify but services are not clinically indicated, LACDMH Quality Assurance recommends consulting with a colleague and/or supervisor. If the decision is that services are not clinically indicated, the assessment should clearly state the decisions made, and the reason for the decisions, and the individual should be referred out to any other appropriate services (e.g. Managed Care Plan for Non SMHS).

7. Do we need to issue an NOABD if the client does not meet criteria to access SMHS and/or if it is determined SMHS would not be medically necessary?

   Yes. If SMHS will not be provided, an NOABD – Service Delivery will need to be issued.

8. If a client does not meet criteria to access SMHS after the assessment is completed, can we proceed with treatment?

   No. If a client does not meet criteria to access SMHS, referrals to non-SMHS through the Managed Care Plans or other treating systems (e.g. Regional Center) should be considered in order to free up capacity for clients who need SMHS level of care.

9. How are "clinically appropriate services" defined?

   The new medical necessity language provides overall direction on what are considered "clinically appropriate services." For beneficiaries 21 and over, medically necessary and clinically appropriate services are services that are "reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain." For beneficiaries under 21, medically necessary and clinically appropriate services are services that are "needed to correct or ameliorate a mental health condition." Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary/clinically appropriate.

Diagnosis

10. Given the new criteria to access SMHS, can we open an episode and/or clinical record with a z-code or "excluded" diagnosis and claim to Medi-Cal?

Yes. An episode and/or clinical record may be opened with a deferred diagnosis (e.g. Z03.89), other z-code or any other valid ICD-10 diagnosis code. All claims must have a valid ICD-10 diagnosis code.

11. Is there a limit to how long a deferred diagnosis or other z code can be used?

    The LACDMH Quality Assurance Unit is awaiting further guidance from the State DHCS. For the time being, we recommend providing a more specific diagnosis following the completion of the assessment and in-line with generally accepted standards of care.

12. Would it be an audit finding if a more general ICD-10 diagnosis is used (e.g. an unspecified diagnosis)?

    No. Using a more general or unspecified ICD-10 diagnosis code would not be an audit finding. Diagnosis is no longer a reason for recoupment. The most clinically accurate and appropriate diagnosis should be used.

13. For clients with co-occurring medical or substance use diagnoses, would there be any audit concerns if the medical or substance use diagnosis is primary and the mental health diagnosis is secondary?

    No. Placing the substance use or medical diagnosis as the primary diagnosis is not a cause for audit disallowance. Claims will not be denied if the ICD-10 diagnosis code associated to the claim is a substance use or medical diagnosis.

Assessment/Treatment Services

14. When documenting in our assessment forms, do we need to specify which of the access criteria the client specifically meets?

    No. The criteria the client meets does not need to be specifically stated but the information in the assessment should make it clear whether the client does or does not meet the criteria to access SMHS.

15. Are treatment SMHS (e.g., rehabilitation or therapy) provided during the assessment period reimbursable when it is determined at the end of the assessment that the client does not meet criteria to access SMHS?

    Yes. The SMHS provided during the assessment period are reimbursable whether or not the client ends up meeting criteria for SMHS at the completion of the assessment. After determining the client does not meet criteria to access SMHS, the client should be referred to the appropriate service delivery system (e.g. Regional Center or Managed Care Plan), if applicable. This is the basis for the CalAIM No Wrong Door policy which is coming later this year.

16. If we are able to provide medically necessary services prior to completing the assessment, do providers even need to complete an assessment?

    Yes! Generally accepted standards of care, Board and ethical standards should govern how practitioners provide services. The completion of an assessment continues to be in line with these standards. Also, the Department of Health Care Services (DHCS) continues to require an assessment as part of Medi-Cal documentation standards.

17. In the CalAIM training video, TCM services were provided as examples of medically necessary services. Are only TCM services being allowed during the assessment period?

    No. Other SMHS can also be provided prior to the completion of the assessment and treatment plan if it is considered to be medically necessary.

18. Is a treatment plan still required to provide treatment?

    Yes. Practitioners should still be completing treatment plans. However, if medically necessary services are provided without a treatment plan, those services will not be disallowed. Disallowances will now be based on fraud, waste, and abuse and not on technical documentation deficiencies.