WELCOME
SA 2 ADULT QIC
SEPTEMBER 21, 2023

PLEASE JOIN VIA MICROSOFT TEAMS MEETING OR CALL IN AT

+1 323-776-6996 Conference ID: **308 664 841**#

ONCE YOU'VE JOINED, PLEASE ENTER YOUR NAME AND THE

AGENCY/CLINIC(S) YOU'RE REPRESENTING INTO THE CHAT BOX

THANK YOU!!

Attendees

Please click this link in the CHAT BOX OR SCAN THE QR BELOW to access the sign in sheet:

https://forms.office.com/g/DUrVdgvTsE

Agenda & Best Practices Sharing Topics:

- All Provider Mtg Take-Aways
- OCMHC New Workflow
- How your Staff get QA/QI information

Network Adequacy Certification

External Quality Review Organization (EQRO)

Quality Improvement

- Review of CANS-IP and PSC-35

Quality Assurance

- QA on the Air
- Key Findings from DHCS Triennial Chart Review 2021/2022
- Policy & Technical Development
  - Draft QA Bulletin: Organizational Providers Manual Updates
  - Payment Reform
  - Screening and Transition
- Training & Operations
  - LE Chart Reviews
  - Collaborative Documentation Training
  - QA Contacts Website Updates
  - QA Knowledge Assessment

Upcoming Webinars

Resources

Network Adequacy Certification

Mandated annual certification by the Department of Healthcare Services (DHCS) to certify the adequacy of our network and ensure we are in compliance with the State standards for access to services, including network adequacy and timely access standards

Certification focused on:

- Network Capacity and Composition (provider to beneficiary ratios)
- Time or distance standards
- Timely access
- Language assistance capabilities
- Mandatory provider types
- Continuity of Care and Transition of Care
- System infrastructure

Submission scheduled for **November 1st**

- Certification consists of submission of access to care data (SRL, SRTS), Network Adequacy Certification Tool (from NAPPA), and other documents pulled by QA staff

External Quality Review Organization (EQRO)

Mandated annual review by an agency contracted with the Department of Healthcare Services (DHCS)

Review focused on:

- **Access to Care**
- **Timeliness of Care**
- Quality of Care
- Outcomes of Care

EQRO Review scheduled for **October 16th -18th**

- Review consists of focus group sessions
- With DMH admin staff
- With Service Area focus areas (SA 6 and 8 – Client/Family and Provider Groups)
- Review of materials submitted by LACDMH

Peer Support Services by Certified Peer Specialists

LACDMH has finalized the set-up of the Peer Support Service procedure codes and IBHIS is prepared to accept claims for dates of service on or after July 1, 2023.

The following is additional information regarding Peer Support Services by Certified Peer Specialists:

- **Certified Peer Specialists shall utilize the following two Peer Support Service procedure codes only,**
  - H0025: Group Peer Support
  - H0038: Individual Peer Support

  Note: If claims were previously submitted with other service codes (i.e., H2017, T1017, H0032, etc.), please resubmit them with one of the above correct peer codes.

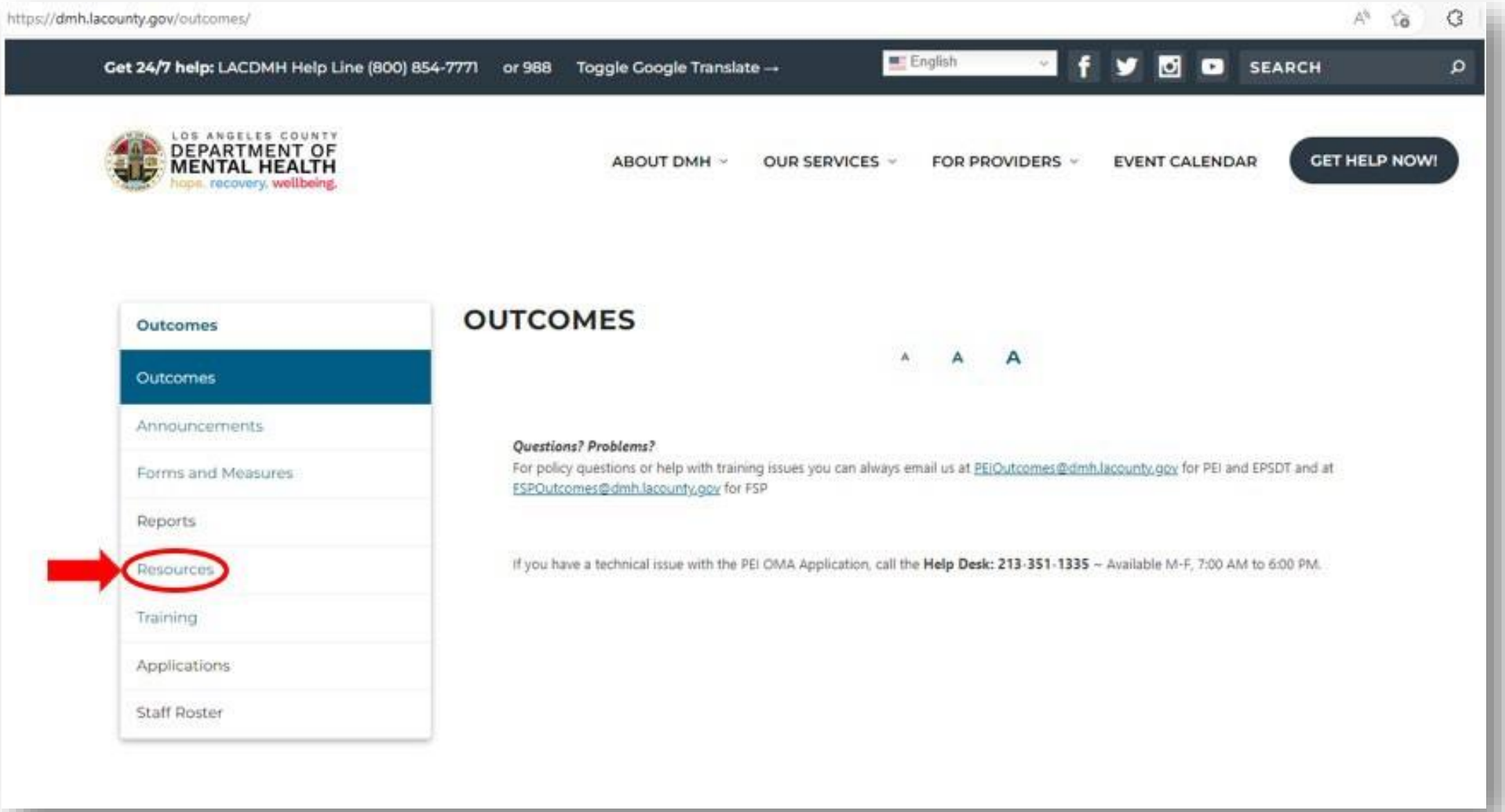
- **Peer Support Service codes were added to all provider sites that were certified for Targeted Case Management (T1017).**
- **Peer Support Service claims have all the same requirements of the 837P claim and documentation.**

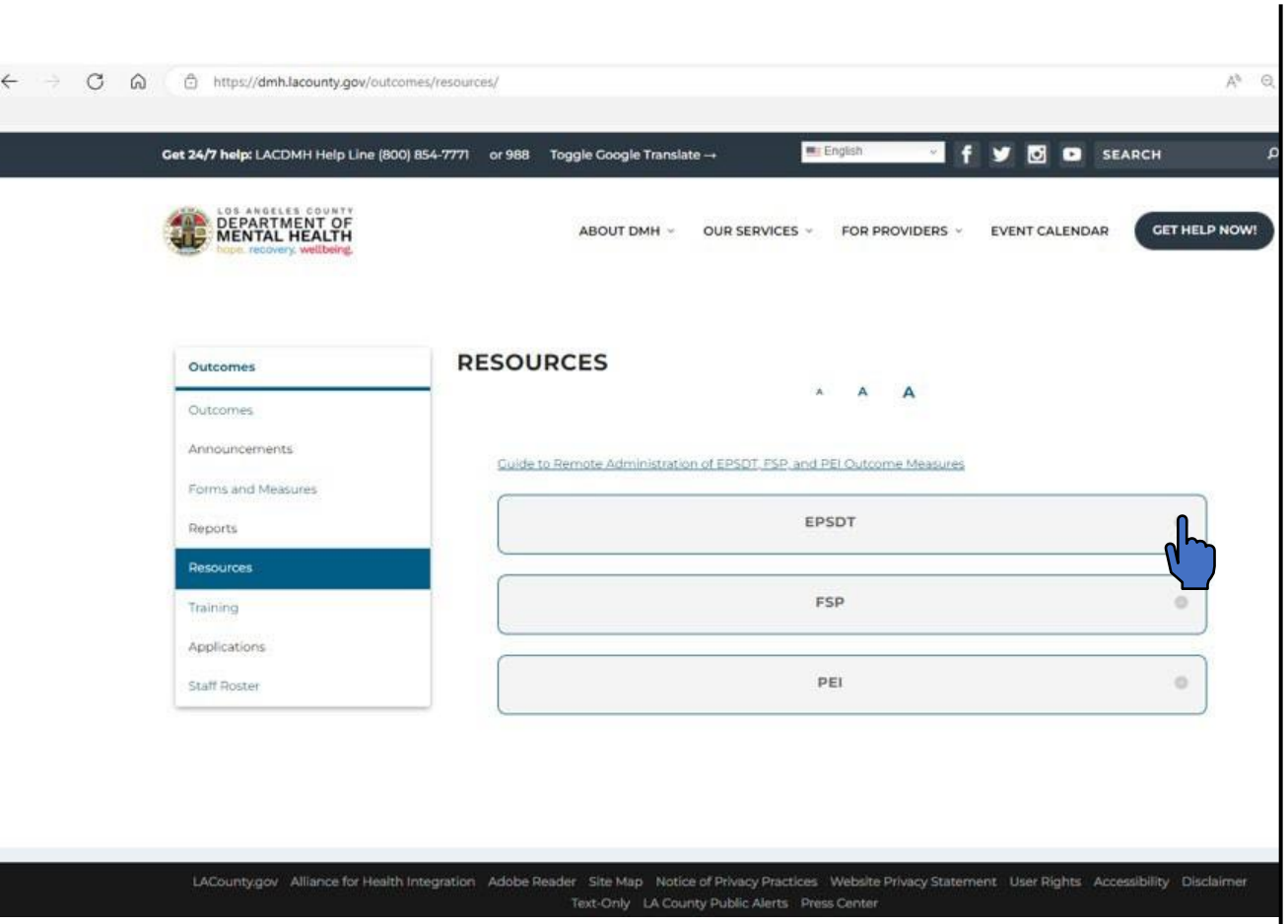
Outcomes and Quality Improvement Updates

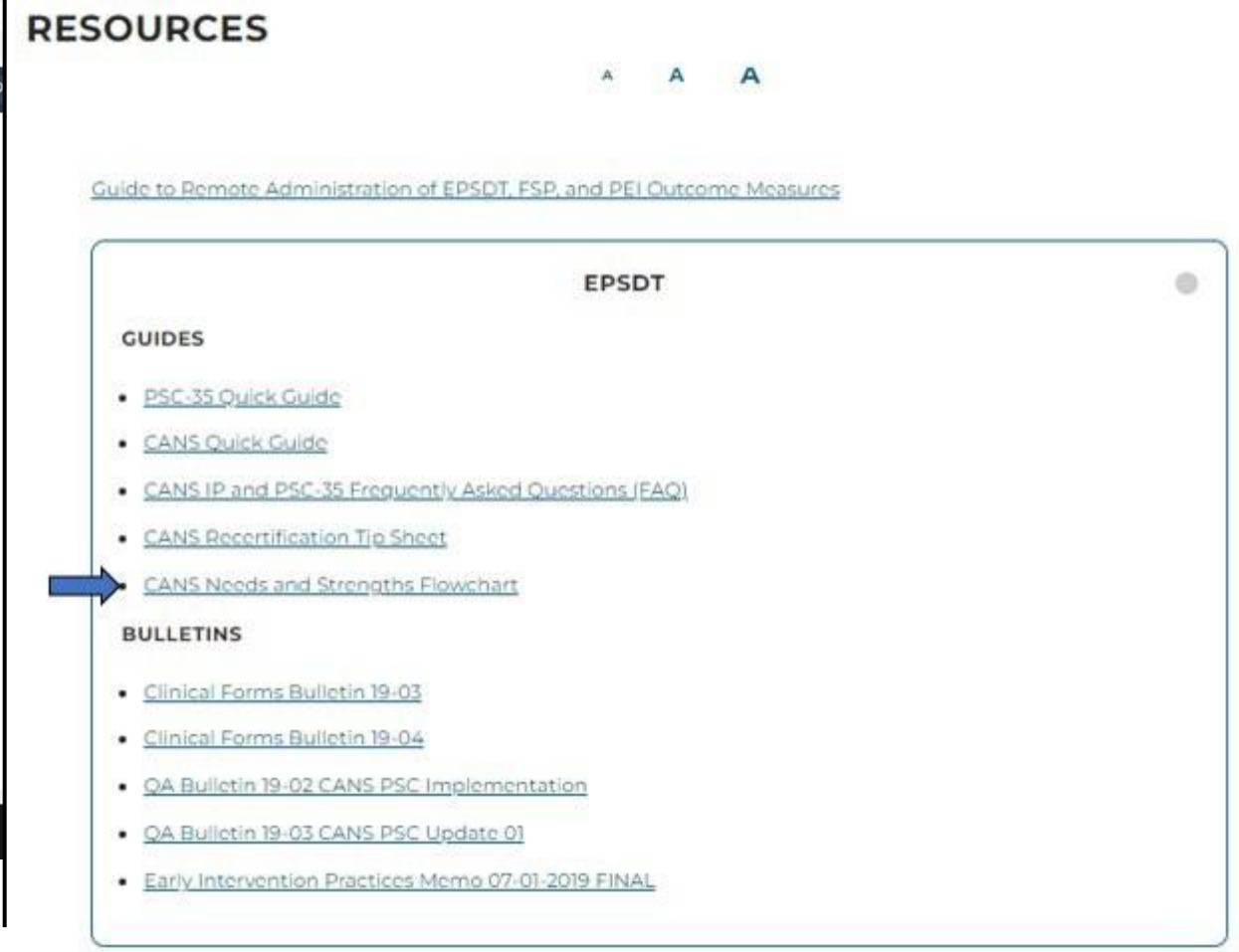
CANS-IP and PSC-35

DMH Outcomes Website

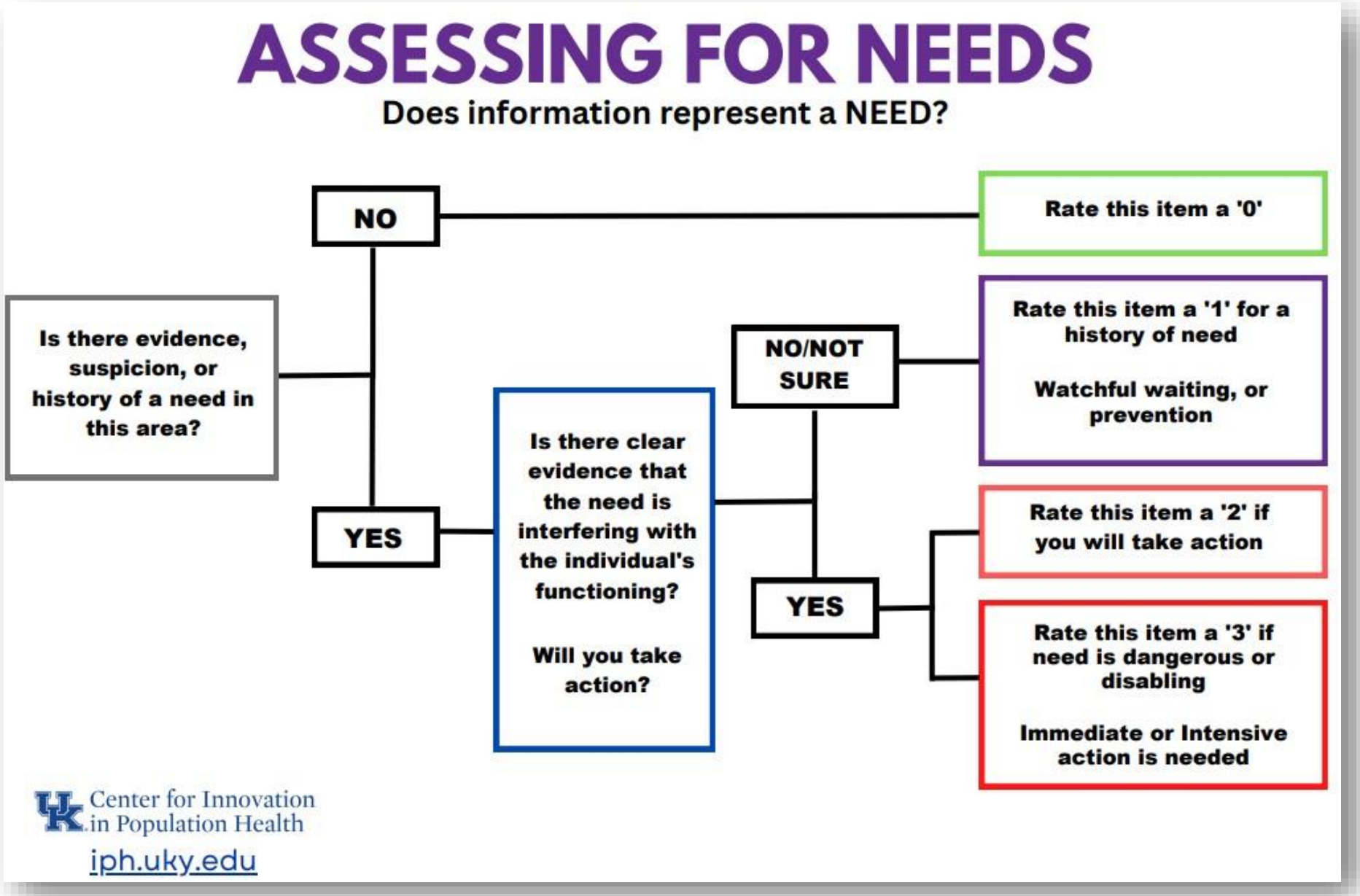
[Outcomes - Department of Mental Health (lacounty.gov)](https://dmh.lacounty.gov/outcomes/)



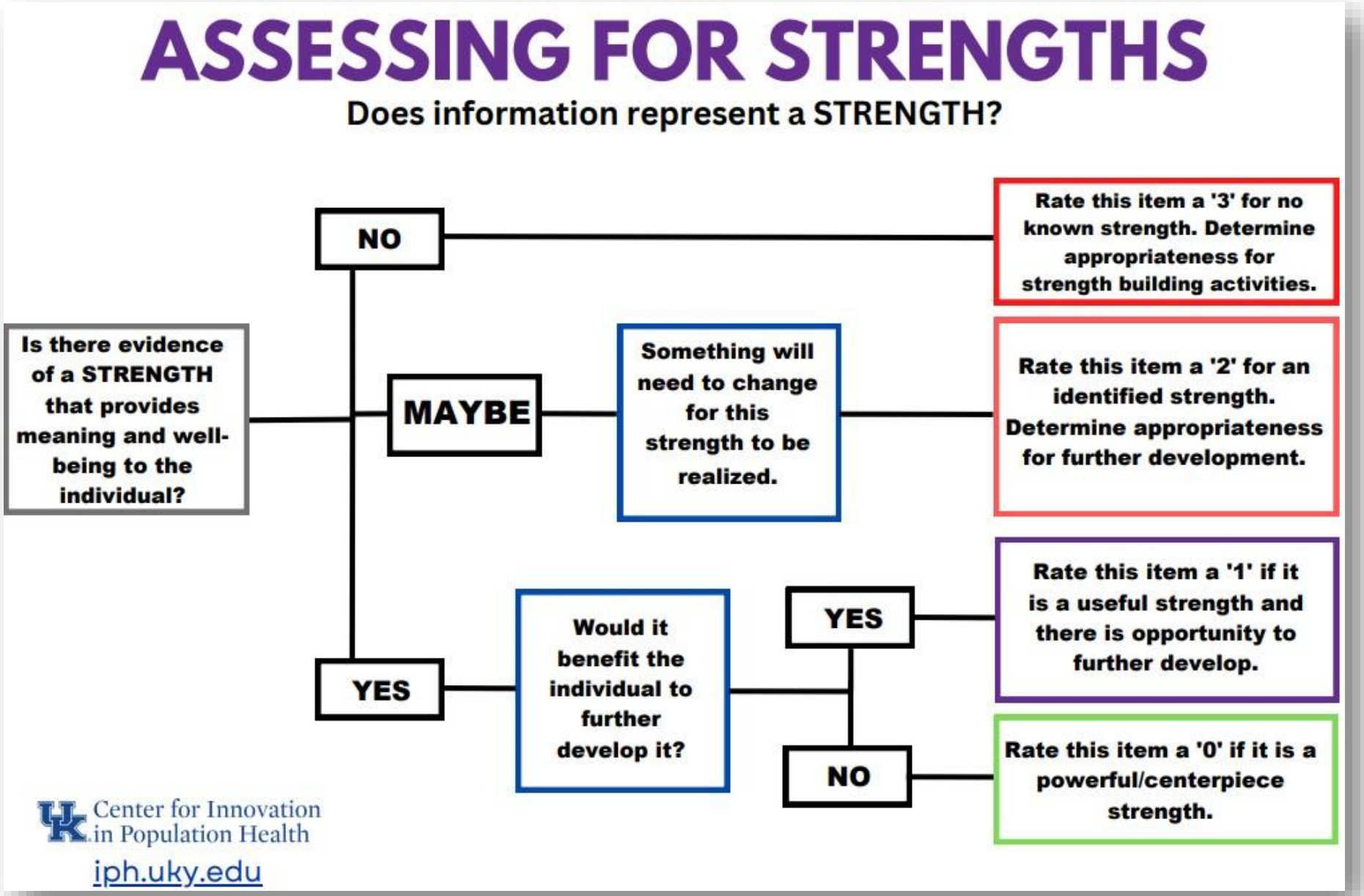

https://dmh.lacounty.gov/outcomes/resources/
Get 24/7 help: LACDMH Help Line (800) 854-7771 or 988 Toggle Google Translate →
English
SEARCH
LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.
ABOUT DMH
OUR SERVICES
FOR PROVIDERS
EVENT CALENDAR
GET HELP NOW!
Outcomes
Outcomes
Announcements
Forms and Measures
Reports
Resources
Training
Applications
Staff Roster
RESOURCES
A A A
Guide to Remote Administration of EPSDT, FSP, and PEI Outcome Measures
EPSDT
FSP
PEI
LACounty.gov Alliance for Health Integration Adobe Reader Site Map Notice of Privacy Practices Website Privacy Statement User Rights Accessibility Disclaimer
Text-Only LA County Public Alerts Press Center


RESOURCES
A A A
Guide to Remote Administration of EPSDT, FSP, and PEI Outcome Measures
EPSDT
GUIDES
PSC-35 Quick Guide
CANS Quick Guide
CANS IP and PSC-35 Frequently Asked Questions (FAQ)
CANS Recertification Tip Sheet
CANS Needs and Strengths Flowchart
BULLETINS
Clinical Forms Bulletin 19-03
Clinical Forms Bulletin 19-04
QA Bulletin 19-02 CANS PSC Implementation
QA Bulletin 19-03 CANS PSC Update 01
Early Intervention Practices Memo 07-01-2019 FINAL

CANS Flowchart for Needs



CANS Flowchart for Strengths



Roadmap of CANS/PSC Webinar Series 2023-2024

1st webinar 6/22/23
- Poll Questions
- Data tip: Fundamentals of the CANS & PSC
- Data Analysis: Common errors of the CANS & PSC
- Spotlight Resource: CANS Recertification Tipsheet

2nd webinar 8/31/23
- Data Tip: PSC (Caregiver declined to respond)
- Data Analysis: PSC case scenarios (multiple respondents)
- Spotlight Resources: PSC Quick Guide & PSC Scoring Sheet
- Administration Tips for the PSC

3rd webinar Jan 2024
- Data Tip: Panel discussion on workflow approach for CANS & PSC; CANS certification process
  - 2 D/O & 2 L/E share their experiences

4th webinar April 2024
- Data Analysis: CANS Client Level Report
  - Launch EPSDT Learning Lab

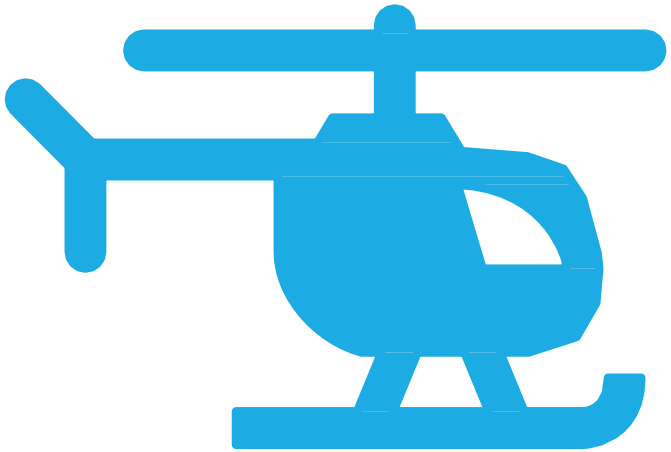
5th webinar July 2024
- Data Analysis: Analyzing CANS data
  - LACDMH
  - L/E Provider

6th webinar Oct 2024
- Data Analysis: CANS Level of Care (LOC)
  - LACDMH
  - L/E Provider

Available Resources for Providers

- CANS-IP and PSC-35 FAQ
- CANS and PSC Quick Guides
- CANS Recertification Tip Sheet
- CANS Needs and Strengths Flowchart
- Clinical Forms Bulletin 19-03 and 19-04
- QA Bulletins 19-02 and 19-03
  - All can be accessed at: Resources - Department of Mental Health (lacounty.gov)
- PSC Scoring Sheet
  - Accessed at: Forms and Measures - Department of Mental Health (lacounty.gov)
- Clinical Utility of the CANS for Directly Operated Supervisor Training
  - Accessed at: TRAININGS/EVENTS - Department of Mental Health (lacounty.gov)
- DMH PEI Outcomes Inbox for questions and/or information about CANS-IP/PSC-35 at peioutcomes@dmh.lacounty.gov

QA Updates



QA on the Air

- The next QA on the Air will be held on **Wed.**, **September 27th from 9:00-10:00**

- The webinar will continue focus on CPT Code Transformation under Payment Reform

DHCS System Review
FY 2021/2022

Key Findings from DHCS System Review - FY 2021/2022 (conducted September 2022)

- Timeliness - The MHP must meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services.
  - Urgent appointments were not provided within 48 hours
  - It is not evident that the MHP provides Notice of Adverse Beneficiary Determination (NOABDs) to beneficiaries for failure to provide services in a timely manner
  - Added prompts for NOABD issuance in SRTS – will be added to SRL in IBHIS for DO
  - Will be evaluating Urgent Appointments and developing guidelines on when to mark an appointment as urgent

- Practice Parameters - The MHP must disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.
  - No evidence was provided to demonstrate that practice guidelines are disseminated to affected beneficiaries or potential beneficiaries.
  - Will be modifying Practice Parameters to apply to both DO & LE, created links to identified practice parameters on a client webpage
  - For DO, will add links and reference to practice parameters in the Consent for Services

- Primary Contact - The MHP must provide the beneficiary information on how to contact their designated person or entity.
  - LACDMH does not have a process to ensure this information is being provided to the beneficiary
  - DMH Policy 302.03: https://secure2.compliancebridge.com/lacdmh/public/index.php?fuseaction=print.preview&docID=3537
  - Will be added to the QA/QI Annual QA Monitoring for LE providers
  - Will be added to the Welcome Packets for DO providers

- Medication Monitoring - The MHP must implement mechanisms to monitor the safety and effectiveness of medication practices
  - Have process for DO

Key Findings from DHCS Triennial Chart Review - FY 2021/2022
(conducted September 2022)

- **Assessments**
  - Did not include the date the documentation was entered into the clinical record and/or the signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure or job title (this included missing co-signatures when required, e.g., psych intern)
- **Medication Consents**
  - Did not obtain a current written medication consent form signed by the beneficiary nor was there documented evidence of verbal consent agreeing to the administration of each prescribed psychiatric medication
    - No documentation of a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent
  - Did not contain all of the required elements specified in the Organizational Provider's Manual
  - Did not include the date the provider completed and entered the document into the clinical record and/or the signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, job title
- **ICC / IHBS**
  - Lack of evidence that beneficiaries under the age of 21 received an individualized determination of eligibility and need for ICC services and IHBS
    - The beneficiary's diagnoses and symptoms appeared to have necessitated an individualized ICC/IHBS determination (2 or more child-serving systems such as Regional Center, Medical, School) and TAY beneficiaries enrolled in FSP, indicating beneficiary involvement with an intensive SMHS and, therefore, meeting eligibility criteria for ICC and IHBS services
  - For beneficiaries who were receiving ICC services, there was no evidence that a case consultation team or CFT meeting occurred at least every 90 days to discuss the beneficiaries' current strengths and needs

Medication Consent – Required Elements

1. The reasons for taking such medications
2. Reasonable alternative treatments available, if any
3. Type of Medication
4. Range of frequency (of administration)
5. Dosage
6. Method of administration
7. Duration of taking the medication
8. Probable side effects
9. Possible side effects if taken longer than 3 months
10. Consent, once given, may be withdrawn at any time

Informed Consent

• If psychiatric medications are prescribed, there must be a medication specific Informed Consent completed and placed in the Clinical Record that includes the following data elements:
o The reason for taking such medications
o Reasonable alternative treatments available, if any
o Type of medication o Range of frequency (of administration)
o Amount (dosage)
o Method of administration
o Duration of taking the medication
o Probable side effects
o **Possible additional side effects if taken longer than 3 months**
o Consent once given may be withdrawn at any time
o Date of medication consent
o Signature of the person providing the service, type of professional degree and licensure/job title
NOTE**: It is acceptable for the medication consent to include attestations, signed by the provider and client, that the provider discussed each of the required components of the medication consent with the client. The use of check boxes on the medication consent form indicating the provider discussed the need for medication and potential side effects is acceptable as long as the information is included in accompanying written materials provided to the client. The reasons a provider prescribed a medication for a client must be documented in the client's clinical record but is not required specifically on the medication consent form** (Information Notice No.: 17-040).

• For programs whose clients are dependents or wards (children and youth under the jurisdiction of the Juvenile Court), the JV-220 through JV-223 forms may be utilized as the Informed Consent. Use of the JV-220 through JV-223 **forms require additional documentation within the clinical record of (1) the method of administration of the medicine(s), and (2) the possible additional side effects if the medication(s) is taken longer than 3 months**.

• The Informed Consent with the client or guardian must be completed:
a. When a new psychiatric medication is prescribed;
b. At least annually, even in the absence of medication changes; and
c. When the client resumes taking psychiatric medication following documented withdrawal of consent for treatment.

• Directly-Operated programs shall utilize an approved DMH form to document Informed Consent such as the Medication Consent.

ICC/IHBS

Intensive Care Coordination (ICC) / Intensive Home Based Services (IHBS)

- ICC – is a targeted case management service that facilitates assessment of / care planning for / and coordination of services
  - ICC is intended to link clients to services provided by other child-serving systems, to facilitate teaming, and to coordinate mental health care
  - If a client is involved in two or more child-serving systems, providers should utilize ICC to facilitate cross-system communication and planning
- IHBS – are mental health rehabilitation services aimed at helping the child/youth build skills necessary for successful functioning in the home and community / and improving the child/youth's family's ability to help the child/youth successfully function in the home and community
- To effectively provide ICC and IHBS, providers should utilize the principles of the Integrated Core Practice Model (ICPM). Specifically, there must be a Child and Family Team (CFT) established to guide services https://file.lacounty.gov/SDSInter/dmh/1078650_IntensiveCareCoordinationServicesPowerpoint9-23-20.pdf

NOTE: *a child/youth is not required to be enrolled in an intensive program (e.g., FSP or Wraparound) in order for the child or youth to receive ICC and/or IHBS*

ICC & IHBS are very likely to be medically necessary for children/youth who:

a) Are receiving, or being considered for Wraparound, Intensive Field Capable Clinical Services (IFCCS), Full Service Partnership (FSP) or Intensive Services Foster Care (ISFC);

b) Are receiving, or being considered for specialized case rate due to behavioral health needs;

c) Are being considered for other intensive SMHS, including but not limited to TBS or crisis stabilization or crisis intervention;

d) Are currently in or being considered for high-level-care institutional settings such as group homes (RCL 10 or above) or Short Term Residential Therapeutic Programs (STRTP);

e) Have been discharged within 90 days from, or currently in or being considered for, placement in a psychiatric hospital or 24-hour mental health treatment facility (e.g. psychiatric inpatient hospital, psychiatric health facility (PHF), community treatment facility, etc.);

f) Have experienced two or more mental health hospitalizations in the last 12 months;

g) Have experienced one or more placement changes within 24 months due to behavioral health needs;

h) Have been treated with two or more antipsychotic medications at the same time over a three-month period;

i) If the child is zero through five years old and has more than one psychotropic medication, the child is six through 11 years old and has more than two psychotropic medications, or the child is 12 through 17 years old and has more than three psychotropic medications;

j) If the child is zero through five years old and has more than one mental health diagnosis, the child is six through 11 years old and has more than two mental health diagnoses, or the child is 12 through 17 years old and has more than three mental health diagnoses;

k) Have two or more emergency room visits in the last 6 months due to primary mental health condition or need, including but not limited to involuntary treatment under California Welfare and Institutions Code section 5585.50;

l) Have been detained pursuant to W&I sections 601 and 602 primarily due to mental health needs; or

m) Have received SMHS within the last year and have been reported homeless within the prior six months.

Updates to the Organizational Provider’s Manual

- 0RGANIZATIONAL PROVIDER'S MANUAL Final 9-14-23.pdf

- QA Bulletin 23-05 Organizational Providers Manual Updates.pdf

Draft QA Bulletin – Organizational Provider's Manual

The Organizational Provider's Manual (the Manual) has been revised to account for Department of Health Care Services (DHCS) changes under California Advancing and Innovating Medi-Cal (CalAIM), State Plan Amendment (SPA) 22-0023, the DHCS Billing Manual, and DHCS issued Frequently Asked Questions. The Manual has been updated to include information contained in QA Bulletin 23-04 CalAIM Payment Reform and QA Bulletin 22-11 Screening and Transition Tools.

In addition, updates were made based on changes in Los Angeles County Department of Mental Health (LACDMH) requirements related to authorizations.

Updates to the Manual include:

1. Chapter 1 Reimbursement Rules:
    a. Updated language related to "Under the direction of" per SPA 22-0023.
    b. Removed travel time reimbursement language and updated language on what is reimbursable based on CalAIM Payment Reform updates
2. Chapter 1 Universal Screening: Added section on universal screening per QA Bulletin 22-11
3. Chapter 1 Co-Occurring Disorders: Added language per DHCS FAQ
4. Chapter 1 Assessment Requirements:
    a. Added statement that Assessments require the name and signature of the practitioner.
    b. Added statement that the assessment shall include recommendations for medically necessary services and referrals
5. Chapter 1 Progress Note Requirements: Removed reference to travel and documentation time
6. Chapter 1 Transition of Care: Added section on transition of care per QA Bulletin 22-11
7. Chapter 1 Service Components: Updated definitions of the following service components per SPA 22-0023
    a. Assessment
    b. Medication Support Services
    c. Therapy (previously Psychotherapy)
    d. Referral and Linkages (previously Referral)
    e. Psychosocial Rehabilitation (previously Rehabilitation)
    f. Treatment Planning (previously Plan Development)
8. Chapter 1 Service Components: Removed definitions of the following service components per SPA 22-0023
    a. Collateral
    b. Obtaining Informed Consent as it has been removed from the SPA
9. Chapter 2 Documentation and Claiming: Updated language per Payment Reform requirements and removed requirements no longer in effect
10. Chapter 2 Mental Health Services:
    a. Added statement about who may be involved in the contact
    b. Added how the service may be provided
    c. Updated list of service components
11. Chapter 2 Medication Support Services:
    a. Updated definition
    b. Added statement about who may be involved in the contact.

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    c. Added how the service may be provided
    d. Updated list of service components
    e. Updated informed consent language
12. Chapter 2 Crisis Intervention:
    a. Added statement about who may be involved in the contact
    b. Added how the service may be provided
    c. Updated list of service components
13. Chapter 2 Intensive Home-Based Services:
    a. Updated list of service components
    b. Added reference to referral for Full Service Partnership (FSP) and Wraparound as a means to request pre-authorization
    c. Updated length of pre-authorization and removed that the pre-authorization is specific to a funding source
14. Chapter 4 General Rules: Added reference to requirements for Concurrent Review
15. Chapter 4 Psychiatric Inpatient Hospital Services: Updated administrative day criteria language and added Medical Care Evaluation (MCE) requirements

If directly-operated or contracted providers have any questions related to this Bulletin, please contact the QA Unit at QualityAssurance@dmh.lacounty.gov.

Organizational Providers Manual Updates – Chapter 1 Co-Occurring Disorders

Clinically appropriate and covered SMHS are reimbursable even if the client has a co-occurring disorder (e.g., substance use, cognitive, medical disorders). SMHS will not be disallowed simply because the client has a co-occurring disorder as long as all other requirements are met. LACDMH providers may address the client's substance use or other disorder as long as it is in support of treating the clients mental health condition. The session must primarily address the beneficiary's mental health, e.g. symptom, condition, diagnosis, and/or risk factors, which can include co-occurring SUD (DHCS No Wrong Door and Co-Occurring Disorder FAQ). LACDMH providers may not provide stand-alone SUD services.

Organizational Providers Manual Updates – Chapter 1 Assessment Requirements

The assessment shall include a typed or legibly printed name, signature of the service practitioner, and date of signature.

The assessment shall include the licensed practitioner's recommendation for medically necessary services and additional provider referrals, as clinically appropriate. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting physical and mental health must be completed by a practitioner, operating within their scope of practice, who is licensed, registered/waivered, and/or under the direction of a licensed mental health professional (i.e., student professionals in these disciplines with co-signature).

Organizational Providers Manual Updates – Chapter 2 Documentation & Claiming

Documentation and Claiming:

- To ensure multiple encounters of the same service to the same client on the same day by the same practitioner are not denied as duplicate services, a single claim shall be submitted combining the duration of the contacts. (DHCS Billing Manual) For example, if a practitioner provides psychotherapy for crisis to a client for 30 minutes in the morning and provides psychotherapy for crisis to the same client for 30 minutes in the afternoon, the claim would be submitted for 60 minutes for psychotherapy for crisis. Because most electronic health record systems generate claims based on progress notes, a single progress note may be written indicating the total duration of the contacts as well as the content of all contacts for that day. Documentation should be clear that there were multiple contacts. If it is not possible to write a single progress note due to the first note having already been finalized at the point of the second contact, providers may write a second note so long as the added total duration of the two contacts is on one claim to prevent claim denials.

- If during a single service contact multiple activities occur (e.g. Therapy and Targeted Case Management or Targeted Case Management and Rehabilitation) a single progress note may be written and a single claim submitted using the procedure code that describes the primary service provided.

~~The exact number of minutes used by persons providing a reimbursable service shall be reported and billed (CCR §1840.316).~~

- A separate claim must be submitted for each client involved in a group. The units claimed should be the same for all clients in the group using the total duration of direct care for the group. The same code shall also be used on each claim.
- ~~For group services, the staff members' time must be prorated to each client based on the total number of persons receiving the service. This number must include both DMH and non-DMH clients to ensure that Medi-Cal is not claimed time for services to non-beneficiaries.~~

Organizational Providers Manual Updates – Chapter 2 Mental Health Services

MENTAL HEALTH SERVICES

Definition (State Plan Amendment)

Mental Health Services are individual, group or family-based interventions that are designed to provide reduction of the client's mental or emotional disability, restoration, improvement and/or preservation of individual and community functioning, and continued ability to remain in the community consistent with the goals of recovery, resiliency, learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive.

Mental Health Services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

Mental Health Services may be provided face-to-face, by telephone or by telehealth and may be provided anywhere in the community

Service Components (State Plan Amendment)

Mental Health Services include one or more of the following service components:

- Assessment
- ~~Plan Development~~Treatment Planning
- Therapy
- Psychosocial Rehabilitation
- ~~Collateral~~

Organizational Providers Manual Updates – Chapter 2 Intensive Home Based Services

1. Authorization Requirements (DHCS Information Notice No.: 19-026)

   - ✓ IHBS services must be authorized by the Department prior to delivery and claiming.
   - ✓ Providers must request authorization by submitting the Supplemental IHBS Assessment form indicating the clinical need for the service and signed by an Authorized Mental Health Discipline (refer to Clinical Forms Bulletin 20-04) or a referral for Full Service Partnership or Wraparound;
   - ✓ For subsequent authorization requests, providers must request authorization by submitting an updated Supplemental IHBS Assessment form indicating the current clinical need for the service and signed by an Authorized Mental Health Discipline;

For Contracted providers, the documents must be submitted via the Provider Connect module of the Integrated Behavioral Health Information System (IBHIS), Service Request Tracking System (SRTS) or Wraparound Tracking System (WTS). For Directly-Operated providers, the documents must be submitted via secure email to the CCR Division (ChildWelfareAuth@dmh.lacounty.gov).

Once the pre-authorization request is submitted, LACDMH will approve or deny the request within five (5) business days. If a provider determines, as indicated on the supplemental assessment form, that the standard timeframe could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum functioning, LACDMH will make an expedited authorization decision within 72 hours. Once pre-authorized, services shall be authorized for a ~~6~~12-month period ~~or 9,999 minutes, whichever comes first~~. Providers must submit an additional request for authorization prior to the end of the pre-authorized period if the client is to continue with services.

An authorization is valid for any IHBS within a Legal Entity ~~for a given Funding Source~~. A subsequent authorization request must be submitted when (1) an authorization expires and the client continues to need the service~~, (2) the client switches to a new Funding Source,~~ or (2~~3~~) a different Legal Entity will be providing IHBS. A subsequent authorization is NOT needed when a client moves between provider/service locations within a Legal Entity.

CalAIM

Payment Reform / CPT Codes

- LE updated CalAIM rates and the new Primary and Add-On association spreadsheets was sent out on Friday:
  - CalAIM_fee_discipline_proc v.12.2 - 9-7-2023.xlsx
  - LACDMH CalAIM Primary and Add-On Association List - Final - 9-7-2023.xlsx
- Travel claims may be submitted for designated/approved LE programs
- LE providers please continue to hold claims for:
  - Certified Peer Support – please note that per DHCS certified peers will ONLY use the peer support codes for Medi-Cal services
  - Multiple groups to the same client by the same practitioner on the same day
  - Student services
  - MAT report writing
- DO program managers attestations for Direct Care durations were due last Friday
  - Please submit if you have not already

Payment Reform / CPT Codes

Effective July 1, 2023

- No longer bill by the minute: some codes will be in 15 min increments
- Will utilize “add-on” procedure codes
- Only bill for “direct patient care”, documentation/travel time/review of records/etc. will be considered “admin”
- Increased use of modifiers
- Complex rules around which codes can be billed on the same day

QA on the Air

- December: https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10471
- January: http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10537
- February: https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10625
- March: https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10697
- April: https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10782
- May: https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10854
- June: https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10946
- July: https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=11008
- August: https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=11089

QA Bulletin 23-04 CalAIM Payment Reform.pdf

UPDATED: Guide to Procedure Codes 7-26-23 Final.pdf

Access to Care – Monitoring Emails

- All access to care monitoring emails went out last week for Q2 – April, May, June 2023
  - Psychiatry timeliness for Directly Operated will go out shortly
  - Note: For Legal Entity providers, QA is working with CIOB to update the webservices to include submission of psychiatry timeliness
- Any required Plans of Correction are due September 29, 2023
- QA is starting to explore monitoring the average number of days to first offered appointment in addition to the % timeliness

Screening & Transition of Care Tools - Updates

- **Monitoring & Tracking Referrals:**
  - Working with the MCPs on data sharing to monitor and track referrals

- **Provider Feedback**: Use of the Tools and Coordination with MCPs
  - We want feedback on your experience with both sending & receiving the Tools, as well as coordinating/communicating with the MCPs

https://forms.office.com/g/vvVjTbX4tp

Policy & Technical Development Contacts

General Email for P&TD:
QA Policy QAPolicy@dmh.lacounty.gov

Access to Care:
Access to Care AccessToCare@dmh.lacounty.gov

Network Adequacy:
Network Adequacy NetworkAdequacy@dmh.lacounty.gov

IBHIS Error Correction:
DMH IBHIS Error Correction IBHISErrorCorrection@dmh.lacounty.gov

Professional Waivers:
Waivers Waivers@dmh.lacounty.gov

LE Contract Provider Chart Reviews

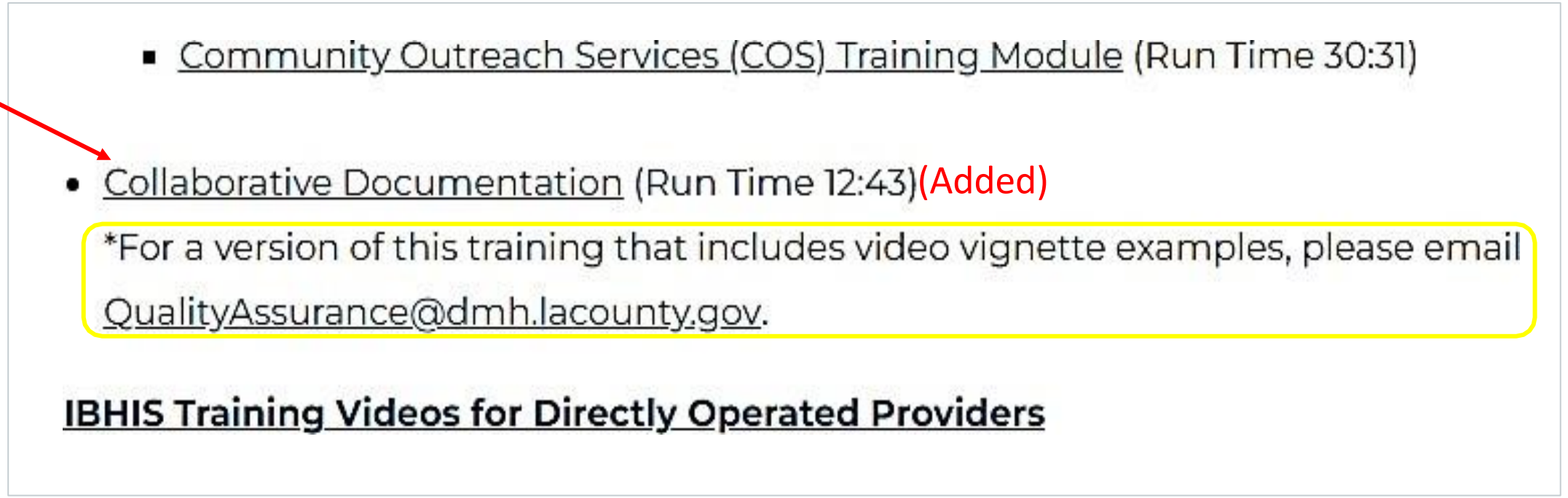
Upcoming Reviews

- Foothill Family Services – Starts mid-October

In the process of coordinating additional reviews for October and November

Collaborative Documentation Online Training Now Available

QA-Training Page: https://dmh.lacounty.gov/qa/qa-training/



- Community Outreach Services (COS) Training Module (Run Time 30:31)

- Collaborative Documentation (Run Time 12:43)(Added)

*For a version of this training that includes video vignette examples, please email QualityAssurance@dmh.lacounty.gov.

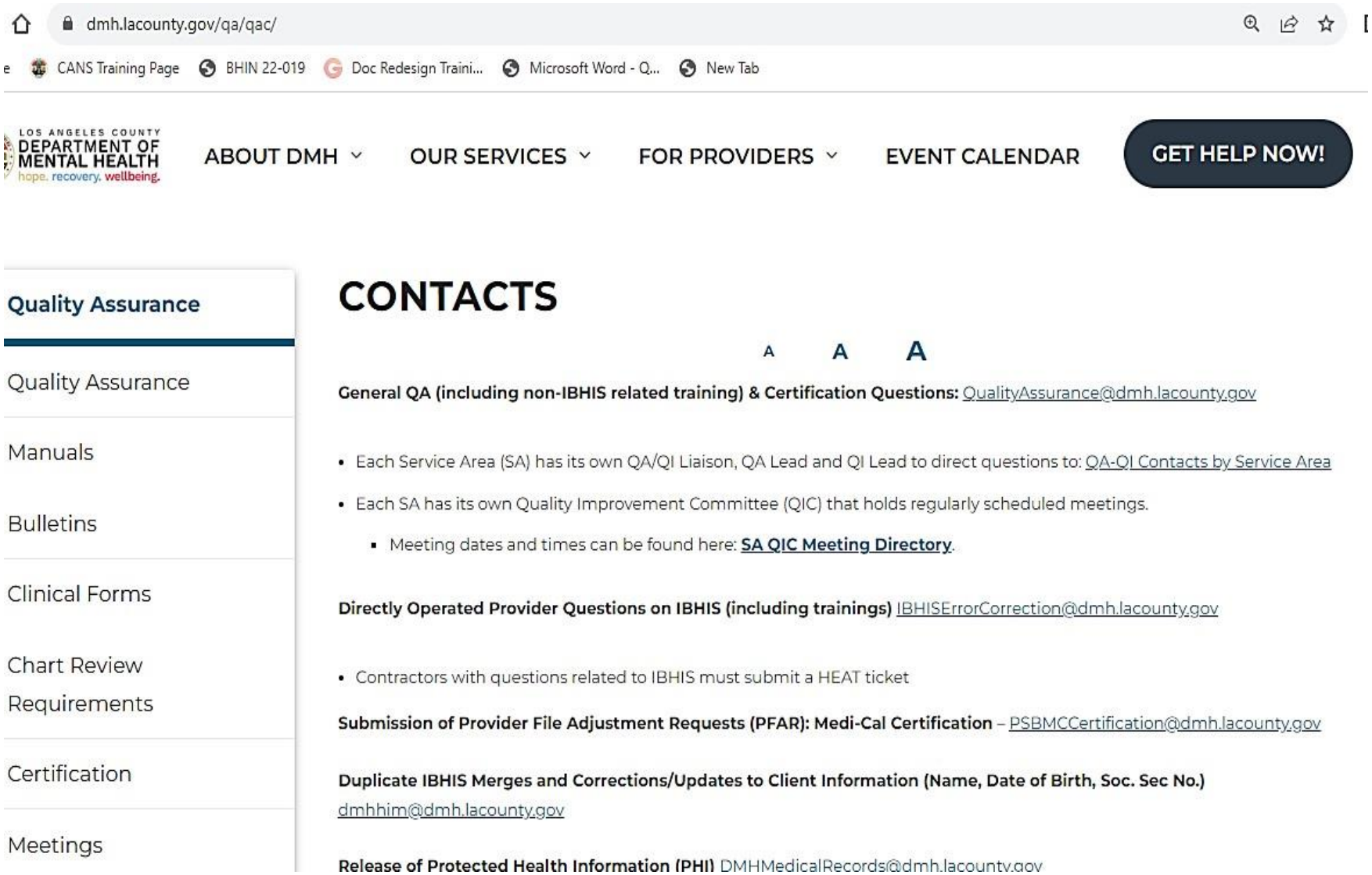
IBHIS Training Videos for Directly Operated Providers

- Can also be accessed through the QA - Collaborative Documentation Page
- Version with video vignette examples can be requested through the QA Mailbox

QA Website Contacts Updates

https://dmh.lacounty.gov/qa/qac/

- SA QIC Meeting Directory link added
- Current general mailbox contacts:
  - IBHIS & non-IBHIS related training
  - PFAR Submission
  - Release of PHI
  - Subpoenas
  - Access to Care
  - Network Adequacy
  - MH Professional Licensing Waivers



QA Knowledge Assessment Survey Process

Purpose – To help identify areas where training is needed on Medi-Cal, Specialty Mental Health Service (SMHS) requirements including those related to documentation and claiming and as a tool in the training process itself.

Process – Anonymous survey, Medi-Cal, SMHS related requirement questions, conducted multiple times a year

Participants – Legal Entity Contract Providers

Information Dissemination – Survey and results distributed to participants via email and made available to Directly-Operated providers and the public via the LACDMH Website's QA Webpage

QA Knowledge Assessment Survey #6

Survey #6 was open from May 24th through August 1st 2023

- Focused on CalAIM documentation requirements
- There were a total of 191 respondents

QA Knowledge Assessment Survey #6 Questions

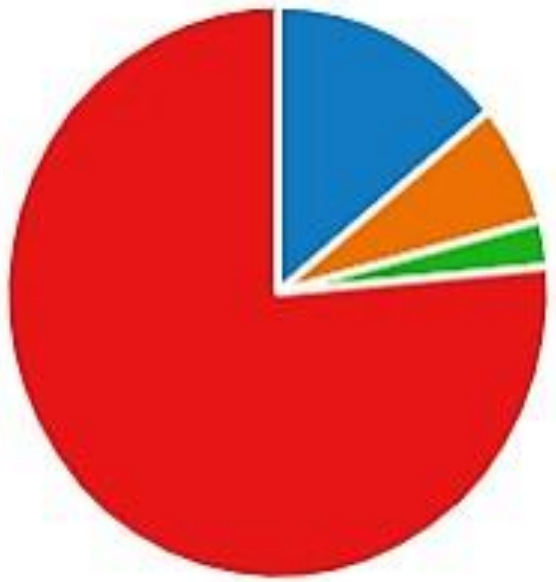
Question 1: Which one of the following is true regarding Assessment?

A. Per Cal-AIM, Assessments must cover 7 required global assessment domains
B. Per Cal-AIM, the first point of contact with the client does not have to be for the purpose of assessment if there is medical necessity for a treatment service prior to the start or completion of the Assessment
C. Per Cal-AIM, the frequency of the Assessment is up to clinical discretion
D. All of the above

QA Knowledge Assessment Survey #6 Questions - Participant Responses

1. **Which one of the following is true regarding Assessment?**

A. Per Cal-AIM, Assessments ...	27
B. Per Cal-AIM, the first point ...	13
C. Per Cal-AIM, the frequency ...	5
D. All the above	146



QA Knowledge Assessment Survey#6 Questions

Client Problems *(includes diagnoses, symptoms, non-mental health conditions, risk factors, etc.)*	Identified by Staff or Client/Significant Support Person?	Date Problem Identified / Added	Date Problem Resolved / Removed	Practitioner Name	Practitioner Title
Major Depressive Disorder	Staff	3/15/23		Anna Sample	Therapist
History of Sexual Abuse	Staff	4/11/23		Joe Test	Case Manager

Question 2: Which one of the following is true regarding the Problem List?

A. Any symptoms, conditions, diagnoses, and/or risk factors identified through the Assessment, diagnostic evaluation, crisis encounters, or other types of service encounters should be entered into the Problem List

B. Medical conditions do not have to be included on the Problem List because they are not mental health related

C. In the sample above, recent changes with this client that took place after completion of the Assessment such as being removed from biological parents should not be added to the Problem List

D. Substance use issues do not need to be included on the Problem List because they are outside of what Medi-Cal SMHS address/treats

QA Knowledge Assessment #6 Questions - Participant Responses

2. **Which one of the following is true regarding the Problem List?**

A. Any symptoms, conditions, ...	177
B. Medical conditions do not ...	6
C. In the sample above, recent...	5
D. Substance use issues do no...	3

QA Knowledge Assessment #6 Questions

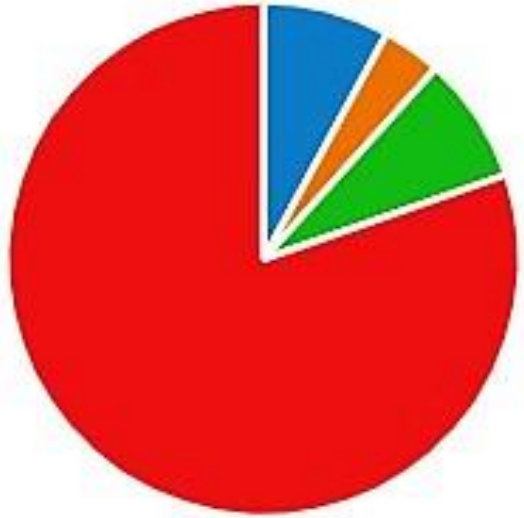
Question 3: Which one of the following is true regarding Treatment Plans/Care Plans?

A. With Cal-AIM, the formal Client Treatment Plan (CTP), with its numerous required data elements (e.g., specific observable and/or specific quantifiable goals/treatment objectives) is no longer required for any services or programs except for STRTPs
B. Per Cal-AIM, for specific services (e.g., TCM, ICC, TBS, IHBS, TFC, Peer Support) the development and periodic revision of a Care Plan is not required
C. The Care Plan for specific services (e.g., TCM, ICC, TBS, IHBS, TFC and Peer Support) may be documented in the Progress Note within the Next Steps section
D. Both A and C

QA Knowledge Assessment Survey #6 Questions - Participant Responses

3. **Which one of the following is true regarding Treatment Plans/Care Plans?**

A. With Cal-AIM, the formal Cl...	15
B. Per Cal-AIM, for specific ser...	7
C. The Care Plan for specific se...	15
D. Both A and C	151



QA Knowledge Assessment Survey #6 Questions

Question 4: Which one of the following is true regarding Progress Notes?

A. The focus of a progress note is describing what Specialty Mental Health Service was provided to address the client's mental health needs (e.g., symptoms, condition, diagnosis, and/or risk factors) and the planned next steps in treatment

B. Although with Cal-AIM, the practitioner has up to 3 business days to complete the progress note, best practice is still to complete/finalize progress notes as soon as possible, ideally collaboratively with the client

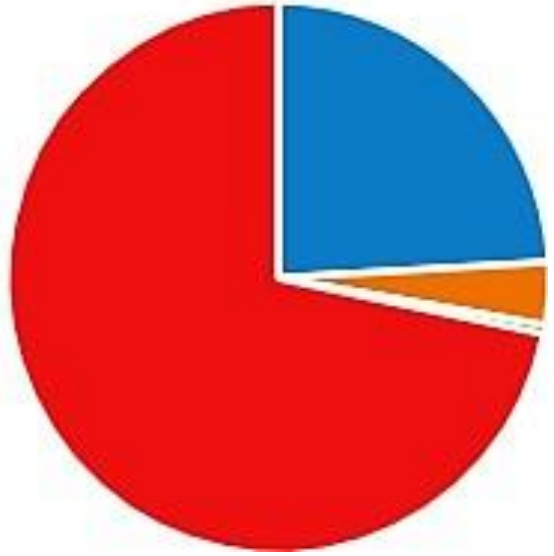
C. With Cal-AIM, discharge summaries are required

D. Both A and B

QA Knowledge Assessment #6 Questions - How Participants Responded

4. Which one of the following is true regarding Progress Notes?

A. The focus of a progress not...	46
B. Although with Cal-AIM, the ...	7
C. With Cal-AIM, discharge su...	1
D. Both A and B	137



QA Knowledge Assessment Survey

- Full answer rationales and countywide results for Survey #6 are available on QA website's Knowledge Assessment Surveys page

https://dmh.lacounty.gov/qa/knowledge-assessment-surveys/

- Next survey, #7, in development and will focus on Payment Reform

QA Knowledge Assessment Survey Process

- Feedback welcome.
- Please let us know how we can make this process the most helpful for you!
- Drop us a note in the QA mailbox
  - QualityAssurance@dmh.lacounty.gov

Training & Operations Contacts

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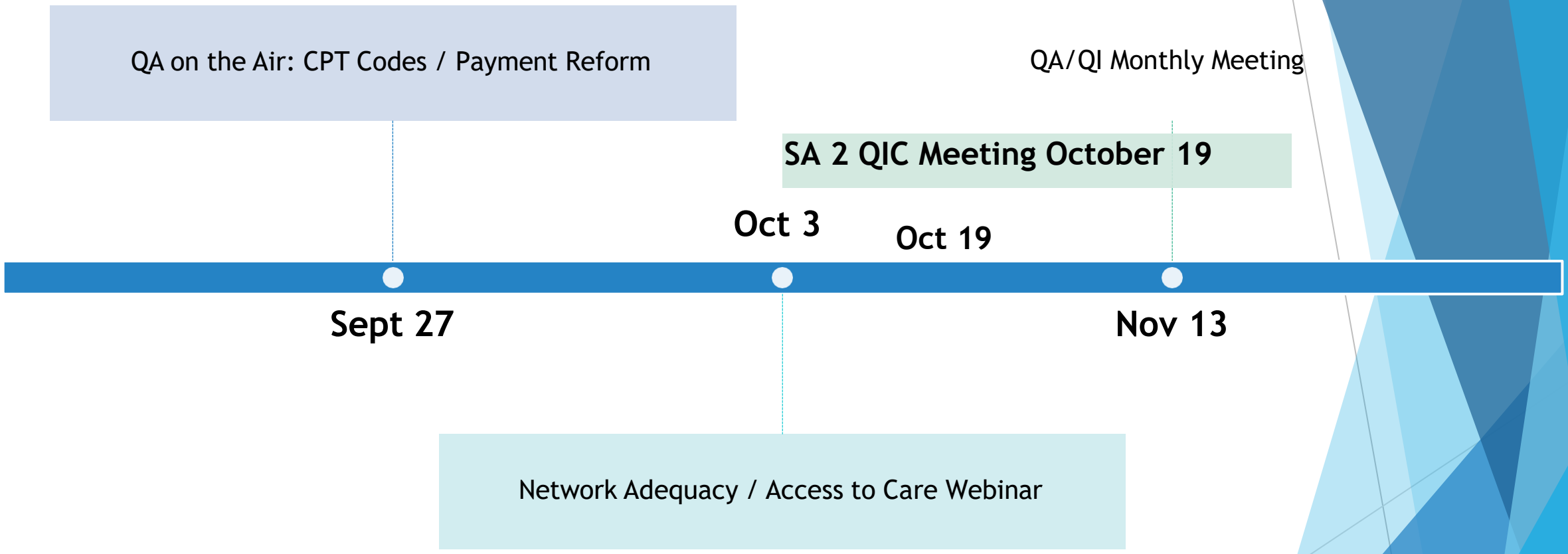
QA on the Air: CPT Codes / Payment Reform
QA/QI Monthly Meeting
SA 2 QIC Meeting October 19
Oct 3
Oct 19
Sept 27
Nov 13
Network Adequacy / Access to Care Webinar

Resources

Effective January 1, 2022

New Criteria to Access SMHS & Medical Necessity

Criteria to access SMHS and Medical Necessity are now separate

- **Criteria to Access SMHS:** Applies to a person (is this person eligible to receive SMHS?)
  - ✓A mental health diagnosis is no longer a prerequisite for receiving SMHS
  - ✓No more "Included" Diagnosis List – can be a mental health disorder or suspected mental health disorder not yet diagnosed per DSM and ICD
  - ✓Those w/ a condition placing them at high risk due to trauma are able to access SMHS
- **Medical Necessity:** Applies to services (is the service provided clinically appropriate?)

- **QA Bulletin:** http://file.lacounty.gov/SDSInter/dmh/1117880_QABulletin21-08UpdatedCriteriatoAccessSMHS.pdf
- **Training:** http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=9640
- **FAQs:** http://file.lacounty.gov/SDSInter/dmh/1119877_QABulletin21-08FAQs.pdf

Effective July 1, 2022

No Wrong Door

Clinically appropriate and covered SMHS are covered and reimbursable Medi-Cal services even when:

1) Services are provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met;
2) The beneficiary has a co-occurring mental health condition and substance use disorder (SUD); or
3) NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

QA Bulletin: http://file.lacounty.gov/SDSInter/dmh/1126524_QABulletin22-06NoWrongDoor.pdf

Training: http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10092&utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=

Effective July 1, 2022

Diagnosis Codes Information Notice

The following options during the assessment phase may be used when a diagnosis has yet to be established:

1. Non-Diagnosing Staff may use Z55-Z65
2. Diagnosing Practitioners may use any appropriate, valid ICD code including Z codes

QA Bulletin: http://file.lacounty.gov/SDSInter/dmh/1126541_QABulletin22-05FirstPointofContacts.pdf

Training: http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10092&utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=

Effective July 1, 2022

Documentation Redesign

Assessments
- Greater integration of the CANS
- Requirements will focus on "domains" that are required and not specific data elements
- No frequency requirements – update as clinically needed

Treatment Plans
- Only required for TCM, ICC, and Peer Support Services
- No specific data element requirements
- Medication Consent is still required

Problem List
- Should be updated regularly/ongoing basis

Progress Notes
- Should support the service provided
- Include narrative describing the service, including how it addressed the identified need
- Include next steps (planned action steps, updates to the problem list)

QA Bulletin: http://file.lacounty.gov/SDSInter/dmh/1125775_QABulletin22-04DocumentationRedesignforSMHS.pdf

Organizational Providers Manual: http://file.lacounty.gov/SDSInter/dmh/1132980_ORGANIZATIONALPROVIDER_SMANUAL.pdf

Training: http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10092&utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=

Peer Support Services

DHCS July 1, 2022

Peer Support Services is a new covered SMHS Medi-Cal benefit effective July 1, 2022

These services must be provided by a Certified Peer Support Specialist

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.

The services will include :

Educational Skills Building Groups (H0025)

Engagement (H0038)

Therapeutic Activity (H0038)

Status/Update:

- ✓ Peer Support Services have been added to the Org Manual and Guide to Procedure Codes
- ✓ QA is updating NAPPA/IBHIS to include a new category/discipline for Certified Peer Support Specialist – a notice will go out when it is available with direction on claiming

Screening and Transition Tools

Effective January 1, 2023

DHCS will be requiring the use of standardized screening and transition tools across the State

Goals of the tools:

Screening tool: to facilitate accurate determinations of when care would be better delivered in the MCP or MHP service system.

Can refer over PRIOR to conducting an assessment (currently requires an assessment before referring)

Transition of care tool: to support a client's transition to the other delivery system when their condition changes.

QA Bulletin: https://file.lacounty.gov/SDSInter/dmh/1135783_QABulletin22-11Screening_TransitionToolandAppendix_1_.pdf

Clinical Forms Bulletin:
https://file.lacounty.gov/SDSInter/dmh/1135787_ClinicalFormsBulletin22-02.pdf

Training:

Screenings - https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10551
Transitions - https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10617

Payment Reform Trainings

1. “Understanding Payment Reform for Outpatient Specialty Mental Health Services” - This first training is an overview of Payment Reform and key changes. (22 minutes)

https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10936

2. **Directly Operated Only:** “Understanding the new Payment Reform Progress Notes in IBHIS” – This second training walks through the new progress note forms in IBHIS and how to utilize them. (17 minutes)

https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10937

3. “Understanding Activities Under Payment Reform” – This third training walks through key information on common activities and code selection. The Discipline Specific Activity Sheets referenced in the training will be sent out tomorrow. (26 minutes)

https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10944

Payment Reform / CPT Code Resources

Discipline Specific Activity Sheets - Updated

The Legal Entity sheets include definitions and codes while the Directly Operated only include definitions as IBHIS will derive the codes.

Legal Entity

- Common RN LVN LPT Activities CalAIM LE 7-26-23.pdf
- Common Social Worker MFT and Professional Counselor Activities CalAIM 7-26-23.pdf
- Common Case Managers Activities CalAIM LE 7-25-23.pdf
- Common PharmD Activities CalAIM LE 7-26-23.pdf
- Common MD DO NP Activities CalAIM LE 7-26-23.pdf
- Common Psychologist Activities CalAIM LE 7-26-23.pdf
- Common Certified Peer Activities CalAIM LE 7-25-23.pdf

Directly Operated

- Sent out via email

Chart Review and Training

To achieve the improved access to care and streamlined administrative requirements goal of CalAIM, it is crucial that LACDMH and its network of providers fully embrace the new requirements under CalAIM. To achieve this, the following documents have been updated:

- Chart Review Tool,
- QA Requirements for Directly-Operated and
- QA/QI Report for Legal Entities to account for the new requirements.

Non-compliance with documentation requirements will not have accompanying recoupment

- Shifted reasons for monetary disallowances to instances of fraud, waste and abuse as identified in the DHCS Medi-Cal Specialty Mental Health Services Reasons for Recoupment Fiscal Year 2022-2023

All new and existing providers and practitioners are strongly encouraged to view the videos prior to service delivery.

- Standardized Screening Process
- Access to Care Timeframe Reminders
- Criteria to Access SMHS and Medical Necessity
- Documentation Requirements
- Reimbursement & Claiming
- Standardized Transition Process

QABulletin: https://file.lacounty.gov/SDSInter/dmh/1137613_QABulletin23-02ChartReview_TrainingUnderCalAIM.pdf

Chart Review Tool: https://file.lacounty.gov/SDSInter/dmh/1137357_LACoMHP_ChartReviewTool.pdf

Reasons for Recoupment: https://www.dhcs.ca.gov/Documents/BHIN-22-063-Enclosure-3-SMHS-Reasons-for-Recoupment-FY-22-23.pdf

Training: https://dmh.lacounty.gov/qa/qa-training/